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(In millions of dollars)

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28. Payment for Clinical Diagnostic Laboratory Tests
29. Payment for Parenteral and Enteral Nutrition Supplies

HOUSE BILL				SENATE AMENDMENT			
1987	1988	1989	3-yr. total	1987	1988	1989	3-yr. total
808	−761	75	122	808	−761	75	122
0	0	0	0	0	0	0	0
0	115	255	370		No provision		
(1)	(1)	(1)	(1)		No provision		
15	0	0	15	15	0	0	15
	No provision			−1	−2	−3	−6
580	230	0	810	420	660	630	1,710
180	−590	−750	−1,160	280	370	410	1,060
−155	−355	−590	−1,100	−75	−205	−310	−590
10	15	20	45		No provision		
58	70	167	295	43	50	57	150
0	0	0	0		No provision		
0	0	0	0		No provision		
	No provision			0	0	0	0
905	1,380	260	2,545	405	210	250	865
25	50	45	120		No provision		
6	8	8	22	4	7	7	18
0	0	0	0		No provision		
0	0	−6	−6		No provision		
30	15	20	65	15	15	20	50
6	7	8	21	5	7	8	20
0	0	0	0		No provision		
0	0	0	0		No provision		
	No provision			−255	−340	−370	−965
0	0	0	0		No provision		
0	0	−380	−380		No provision		
0	−70	−105	−175	−50	−200	−250	−500
55	145	50	250	.....	.....	.....	.....
−150	−220	−245	−615	−100	−105	−120	−325
	Not available			50	50	0	100
10	10	10	30	.....	.....	.....	.....
0	0	0	0		No provision		
35	60	70	165		No provision		
15	15	20	50	20	20	20	60
0	0	0	0		No provision		
−10	−70	−90	−170		No provision		
−35	−35	−40	−110		No provision		

Part II—Medicare Provisions—Continued
30. Payment for Oxygen Therapy Services
31. Changing Medicare Appeal Rights
32. Alzheimer's Disease Demonstration Projects
33. Ambulatory Survey
Part III—Utilization and Quality Control Peer Review Organization (PRO) Provisions
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6. Clarification of Eligibility of Homeless Individuals
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12. Continuation of "Case-Managed Medical Care for Nursing Home Patients" Demonstration Project
13. Holding States Harmless in Fiscal Year 1987 Against a Decrease in the Federal Medical Assistance Percentage
14. Independent Quality Review of HMO Services
15. Clarification of Flexibility in State Utilization Review Systems
16. Clarification of Flexibility for State Medicaid Payment Systems for Inpatient Services
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3. Continuation Coverage for Retirees in Cases of Bankruptcies
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2. Deposits of Social Security Contributions by State and Local Government Employers
3. Telephone Excise Tax

HOUSE BILL				SENATE AMENDMENT			
1987	1988	1989	3-yr total	1987	1988	1989	3-yr total
−40	−60	−65	−165		No provision		
4	8	8	20		No provision		
14	14	14	42		No provision		
	No provision			−10	−125	−180	−315
10	17	18	45	4	7	7	18
15	75	85	175	25	85	110	220
	No provision			2	2	2	6
30	100	140	270	30	100	140	270
15	70	100	185	15	70	100	185
0	0	0	0		No provision		
0	0	0	0		No provision		
0	0	0	0		No provision		
0	0	0	0		No provision		
0	0	0	0		No provision		
0	0	0	0		No provision		
0	0	0	0		No provision		
50	0	0	50	50	0	0	50
(1)	(1)	(1)	(1)		No provision		
0	0	0	0		No provision		
0	0	0	0		No provision		
0	0	0	0		No provision		
0	0	0	0		No provision		
0	0	0	0		No provision		
0	0	0	0		No provision		
	No provision			−2	0	0	−2
	No provision			1	2	2	5
42	68	78	188		No provision		
(1)	(1)	(1)	(1)		No provision		
0	0	0	0		No provision		
0	0	0	0		No provision		
(1)	(1)	(1)	(1)		No provision		
	No provision			789	2,095	2,088	4,972
388	290	1,158	1,836	388	290	1,158	1,836
0	1,337	2,290	3,627		No provision		

Part VII—Revenue Provisions—Continued
4. Extension of that Portion of the Federal Unemployment Tax that is Due to Expire on December 31, 1987
5. Accelerated Collection of Certain Excise Taxes
6. Certain Tax Penalties
(a)
(b)
7. Tax Treatment of Conrail Public Sale
8. Denial of Tax Benefits with Respect to Activities in Certain Foreign Countries
9. Benefit Accrual Beyond Normal Retirement Age
10. Port Use Tax and Related Trust Fund; Inland Waterways Fuels Tax and Related Trust Fund
11. Oil Spill Liability Trust Fund and Tax
12. Appropriations for IRS Enforcement
Part VIII—Other Provisions
1. Accelerate General Revenue Sharing Project
2. Customs User Fees

[1] Less than $500,000.

HOUSE BILL				SENATE AMENDMENT			
1987	1988	1989	3-yr total	1987	1988	1989	3-yr total
0	912	1,282	2,194		No provision		
153	1	1	155	298	1	1	300
750	750	750	2,250	750	750	750	2,250
96	219	270	585	237	267	278	782
	Not available				No provision		
	No provision			14	26	28	68
	No provision			(1)	(1)	(1)	(1)
102	154	167	423		No provision		
23	47	50	120		No provision		
	Not available				Not available		
	No provision			−680	0	0	−680
−1,830	−940	−1,000	−3,770		No provision		

I. INCOME SECURITY PROVISIONS

Item	Present Law
1. Elimination of 3-Percent Trigger for Cost-of-Living Increases (Section 10001 of the House bill)	The Social Security Act provides for a cost-of-living adjustment (COLA) for benefits under the Old-Age, Survivors, and Disability Insurance Program, based on the consumer price index (CPI), if the CPI increases by 3.0 percent or more during a specified base period (currently, the third quarter of the prior year through the third quarter of the current year). If the CPI rises by less than 3.0 percent during the base period, a COLA is not provided. In the following year, however, the COLA is based on the accumulated increase in the CPI over 2 years. Several other automatic increase provisions are linked to the social security COLA, and are triggered only if the social security COLA is provided. These include the increase in: a) the maximum amount of earnings taxable under FICA and SECA; b) the amount of earnings exempt from the retirement test; c) the Supplementary Medical Insurance (SMI) beneficiary premium; d) railroad retirement, Supplemental Security Income (SSI), and Veteran's pension benefits; and e) certain eligibility standards for medicaid, food stamps, housing assistance, and Aid to Families with Dependent Children (AFDC).
2. Disinvestment of Social Security Trust Funds	The Old-Age, Survivors, and Disability Insurance (OASDI) program is financed primarily from Social Security taxes on employers, employees, and self-employed persons. Under the normalized tax transfer provisions of current law, the Treasury Department is required at the start of each month to credit the trust funds with an amount equal to the taxes expected to be received during the month. The Treasury Department is also required to invest the assets of the trust funds. Funds must be invested in securities issued (or fully guaranteed) by the Federal Government. The securities issued at the beginning of the month are redeemed as necessary to

House Bill	Senate Amendment
Eliminates the 3-percent trigger for the provision of the social security COLA effective in December 1986. A COLA would be provided in any year in which there has been a measurable increase in the CPI during the specified base period. This would have the effect of assuring that the other automatic increase provisions linked to the Social Security COLA would also rise in any year in which the CPI rises.	Similar provision.
Provides technical clarification for the implementation of the SMI "hold harmless" (mandated by the Deficit Reduction Act of 1984) to assure that the proceeds from rounding social security benefit amounts down to the next lower dollar accrue to the OSADI trust funds.	
Effective date.—Date of enactment.	
Outlay effect (in millions):	***Outlay effect*** (in millions):
Fiscal years: 1987 ..... 808 1988 ..... −761 1989 ..... 75 3-year total 122	Fiscal years: 1987 ..... 808 1988 ..... −761 1989 ..... 75 3-year total 122
No provision.	Establishes rules for investment and disinvestment of the Old-Age, Survivors, and Disability Insurance (OASDI) Trust Funds during periods when the normal borrowing operations of the Treasury Department are constrained because of the debt limit: —the Treasury Secretary is directed to redeem securities held by the trust funds that absent the debt ceiling would not need to be redeemed to meet the program's obligations on a timely basis;

Item	Present Law
	finance benefit payments. Funds not needed to finance current withdrawals are held by the trust funds in the form of invested assets. Governmental securities issued to the trust funds are subject to the statutory limit on the public debt. When that debt limit is reached, the Treasury Department may be unable, without violating the limit, to meet the requirement that an amount equal to expected payroll tax receipts be fully invested at the beginning of the month. In a situation where the debt limit prevents the Treasury Department from utilizing the normal investment and disinvestment procedures, present law does not provide specific guidance as to the alternative procedures to be followed. On several occasions in 1984 and 1985 the Treasury responded to such situations by disinvesting securities held by the trust funds that it would not have been necessary to redeem in the absence of the debt limit constraint. This procedure allowed the Treasury to create sufficient borrowing authority to finance current withdrawals without exceeding the debt limit. In such circumstances, the trust funds may be placed in a position where they will earn less interest than would be the case under normal investment procedures. In addition, the redemption of trust fund holdings to generate cash to meet benefit obligations can result in significant changes in the portfolio of investments held by the funds—changes which would not occur in the absence of a debt limit constraint. Present law contains no mechanism to restore the lost interest or to reconstitute the portfolio of the trust funds. Present law imposes on the Board of Trustees the duties of: —holding the trust funds; —meeting and reporting to the Congress at least once a year; —reporting immediately if they find the balance in a trust fund to be "unduly small";

House Bill	Senate Amendment
	—the amount of such redemptions cannot be greater than the amount which would be redeemed under normal operating conditions; and —if the trust funds have not been issued securities promptly because of debt limit constraints, those securities must be issued as room develops for investment within the debt limit (but only to the extent that the Treasury Department has actually received the Social Security taxes giving rise to those uninvested amounts). Provides that, after the normal trust fund investment and disinvestment procedures have been affected by a period of debt limit constraint, the trust funds will be restored fully as soon as the debt limit is increased: —there is appropriated to the trust funds the amount of any interest that would have been earned, but was not, because of the impact of the debt limit; —the portfolio of the trust funds is to be reconstituted by the issuance or reissuance of securities as necessary to leave the funds with the same holdings they would have had but for the impact of the debt limit; and —a special Trustees' Report to the Congress is to be made detailing trust fund operations during any period of debt limit constraint and describing the actions taken to restore the funds after the end of that period. Revises and clarifies the statutory requirements on the Board of Trustees: —the Treasury Secretary is required to report monthly to the Board of Trustees of the Social Security trust funds on the status of the funds, and is required to notify both the Board and the Congress 15 days prior to the date on which he expects, because of the debt limit, to be unable fully to comply with the transfer or investment requirements of the Act; —funds appropriated or deposited in the Social Security trust funds are to be available immediately and exclusively for trust fund purposes;

I. INCOME SECURITY PROVISIONS—Continued

Item	Present Law
	—recommending improvements to better coordinate Social Security and unemployment compensation; and —reviewing and recommending changes in trust fund management policies.
3. AFDC for Unemployed Two-Parent Families (Section 10101 of the House bill)	*(a) State Option.*—States have the option to provide AFDC to financially eligible two-parent families in which the principal earner is "unemployed," defined as working fewer than 100 hours per month. *(b) Eligibility.*—For eligibility, the law requires that the unemployed parent have worked six or more quarters in any 13-calendar quarter period ending within 1 year before applying for AFDC-UP. NOTE.—States without AFDC-UP programs are: Alabama, Alaska, Arizona, Arkansas, Colorado, Florida, Georgia, Idaho, Indiana, Kentucky, Louisiana, Mississippi, Nevada, New Hampshire, New Mexico, North Carolina, North Dakota, Oklahoma, South Dakota, Tennessee, Texas, Utah, Virginia and Wyoming. The Virgin Islands and Puerto Rico also do not have AFDC-UP.

House Bill	Senate Amendment
	—the Board of Trustees will be required to meet twice, rather than once, each year; and —the duty of the trustees faithfully to execute the responsibilities imposed on them by the Act is explicitly stated. ***Effective date.***—Effective July 1, 1990, repeals a provision enacted in 1983 under which the OASDI trust funds are credited on the first day of each month with the Social Security taxes expected to be collected during the month. Instead, the funds will be credited on a daily basis as the the taxes are received. Otherwise effective on enactment. ***Outlay effect.***—None.
(a) State Option.—Requires all State AFDC programs to offer coverage to financially eligible two-parent families in which the principal earner is "unemployed," defined as working fewer than 100 hours per month. ***(b) Eligibility.***—Permits States to substitute for 4 quarters of the 6 quarters of work, full-time attendance in elementary or secondary school or full-time participation in vocational training, but sets a life-time limit of 4 quarters creditable to vocational training. ***Effective date.***—January 1, 1988. ***Outlay effect*** (in millions): Fiscal years: 1987 ..... 0 1988 ..... 115 1989 ..... 255 3-year total 370	No provision.

I. INCOME SECURITY PROVISIONS—Continued

Item	Present Law
4. Targeting the Use of the Income and Eligibility Verification System (Section 10102 of the House bill)	Section 1137 of the Social Security Act requires that States establish an income and eligibility verification system (IEVS) for certain public assistance programs. Under IEVS, the AFDC, Medicaid, unemployment compensation, Food Stamp and SSI programs must request and make use of IRS unearned income information and quarterly wage information. The Act requires that the use of such information be targeted to those uses which are most likely to be productive in identifying and preventing ineligibility and incorrect payments. Current regulations require that information be requested and verified for *all* applicants and recipients within a 30-day time period. Action can be delayed on up to 20 percent of the information items when collateral verification sources must be contacted.
5. Annual Calculation of Federal Percentage of AFDC Expenditures (Section 10103 of the House bill, Section 652 of Senate amendment)	Prior to enactment of P.L. 99–272, the Federal percentage was calculated between October 1 and November 1 of each even-numbered year. The percentage applied to the two-year period beginning the following October. P.L. 99–272 requires an annual rather than biennial calculation of the Federal percentage beginning in FY 1987. The shift from a biennial to an annual calculation of the Federal percentage occurs in the middle of the two-year cycle and results in a loss of funds for 13 states in FY 1987. NOTE.—According to the Department of Health and Human Services, the States affected are: Arizona, Florida, Georgia, Maine, Minnesota, Missouri, New Hampshire, North Carolina, Ohio, Rhode Island, South Carolina, South Dakota and Virginia.

House Bill	Senate Amendment
	No provision.
Clarifies that the system is to be targeted to those uses which are likely to be most productive by adding that no State shall be required to use information obtained through the system to verify the eligibility of all recipients. Report language calls for a 45-day time period for verification of information received. *Effective date.*—On enactment. *Outlay effect.*—Negligible.	
For FY 1987 only, restores the biennial calculation of the Federal percentage for States that lost funds in the shift to an annual calculation.	Identical provision.

I. INCOME SECURITY PROVISIONS—Continued

Item	Present Law
6. Retroactive Modification of Child Support Arrearages (Section 651 of Senate amendment)	In most States, a child support order can be modified only prospectively; that is, the terms of the modification do not take effect until after the date on which it becomes final. Thus, only future child support payments would be affected. However, a number of States permit the child support award to be retroactively modified. In such States, the court (or administrative entity) has the authority to reduce or nullify arrearages. Further, under the Uniform Reciprocal Enforcement of Support Act (URESA), in interstate cases, the court in the noncustodial parent's State may modify the child support order of the custodial parent's State to the same extent the order could be modified in the State that issued the order.

House Bill	Senate Amendment
Effective date.—October, 1986. ***Outlay effect*** (in millions): Fiscal years: 1987 ..... 15 1988 ..... 0 1989 ..... 0 3-year total 15	***Outlay effect*** (in millions): Fiscal years: 1987 ..... 15 1988 ..... 0 1989 ..... 0 3-year total 15
No provision.	Adds to the child support enforcement program established by title IVD of the Social Security Act a new requirement which States must meet to be in compliance with that program. To meet this new requirement, State laws relating to the enforcement of child support orders must prohibit changes in those orders which are effective on a retroactive basis If the noncustodial parent's circumstances change because of unemployment, illness or another such reason, the amendment requires notification of the custodial parent and the court or entity which issued the child support order of this changed circumstances and his/her intent to have the child support order modified. No modification would be permitted before the date of this notification. ***Effective date.***—On enactment. ***Outlay effect*** (in millions): Fiscal years: 1987 ..... −1 1988 ..... −2 1989 ..... −3 3-year total ..... −6

II. MEDICARE PROVISIONS (PART A)

Item	Present Law
1. Changes in the Part A Deductible (Section 10201 of House bill; Section 603 of Senate amendment)	Medicare's inpatient hospital deductible must, by law, be revised each January. The deductible is revised based on a formula which reflects the average cost of a day of hospital care. The deductible was $400 in 1985, and is $492 in 1986. The Administration estimates that the deductible will increase to $572 in 1987. The deductible is used in computing the coinsurance amount for post-hospital extended care services and in computing the monthly part A premium.

House Bill	Senate Amendment
(a) Inpatient Hospital Deductible for 1987.—Sets the inpatient hospital deductible for 1987 at $500.	***(a) Inpatient Hospital Deductible for 1987.***—Sets the inpatient hospital deductible for 1987 at $520.
(b) Inpatient Hospital Deductible for Years After 1987.—No provision; that is, current law would prevail.	***(b) Inpatient Hospital Deductible for Years After 1987.***—Sets the inpatient hospital deductible for any succeeding year at an amount equal to the inpatient hospital deductible for the preceding calendar year, changed by the same percentage change that applies to PPS payment rates and adjusted to reflect changes in real case mix. Any amount so determined which is not a multiple of $4.00 shall be rounded to the nearest $4.00.
Effective date.—Applies to inpatient hospital services furnished in 1987.	***Effective date.***—Applies to spells of illness beginning on or after January 1, 1987.
Outlay effect (in millions):	***Outlay effect*** (in millions):
Fiscal years:	Fiscal years:
1987 580	1987 420
1988 230	1988 660
1989 0	1989 630
3-year total 810	3-year total 1,710

Item	Present Law
2. Applicable Percentage Increase in Payments for Inpatient Hospital Services (Section 10202 of House bill; Section 601 of Senate amendment)	***(a-c) Rate of Increase, Conforming Amendments, and Promulgation of New Rate.***—The Social Security Amendments of 1983 (P.L. 98-21) authorized the Secretary to determine the rate of increase in the payment rates for hospitals included in the prospective payment system (PPS) for FY 1986 and thereafter; taking into account the recommendations of the Prospective Payment Assessment Commission (ProPAC). HHS issued final rules on September 3, 1985, freezing the PPS payment rates for FY 1986. However, these rules were not implemented because of the enactment of emergency extension legislation which provided that the FY 1986 PPS rates would be frozen at FY 1985 levels through March 14, 1986. COBRA continued the FY 1986 rate freeze until April 30, 1986, and provided for a rate of increase of 1/2 of 1 percent for the remainder of the Federal fiscal year for both PPS and PPS-exempt hospitals. In addition, for FY 1987 and FY 1988, it provided that the update factor may not exceed the rate of increase in the market basket index. The Balanced Budget and Emergency Deficit Control Act of 1985 (P.L. 99-177) reduced the FY 1986 Medicare payments to hospitals by 1 percent beginning March 1, 1986. In proposed rules issued June 3, 1986, HHS provided for an increase of 0.5 percent in the FY 1987 PPS rates and in the target amounts per discharge for PPS-exempt hospitals. In a July 2, 1986, letter to HCFA, ProPAC recommended a 2.2 percent increase in the FY 1987 PPS rates if capital is to be included into the prospective payment system or a 1.9 percent increase without capital, a rate of increase for PPS-exempt children's hospitals of 3.2 percent, and a rate of increase for other PPS exempt hospitals and units of 3.5 percent. ***(d) FY 1988 Update Recommendations.***—The Prospective Payment Assessment Commission is required to issue a report to the Secretary on April 1 of each year with its recommendations on ways to update and improve the prospective payment system. The Secretary is required to promulgate proposed PPS regulations not later than June 1 and final PPS regulations not later than September 1.

House Bill	Senate Amendment
(a) Rate of Increase.—Increases the FY 1987 payment rates for PPS hospitals and PPS-exempt hospitals by 1.0 percent and increases the FY 1988 payment rate by the market basket increase minus 2.0 percent.	*(a) Rate of Increase.*—Increases the FY 1987 payment rates for PPS hospitals and PPS hospitals by 1.3 percent. The marketbasket rate of increase limitation is extended to payment rates for FY 1989.
(b) Conforming Amendments.—Provides for conforming amendments.	*(b) Conforming Amendments.*—No provision.
(c) Promulgation of New Rate.—Requires the Secretary to republish in the Federal Register the determination of the percent increase which will apply for FY 1987, taking into account the amendments made by this section.	*(c) Promulgation of New Rate.*—No provision.
(d) FY 1988 Update Recommendations.—Requires the Secretary to submit a report to Congress by April 1, 1987, providing a documented recommendation on what the Secretary believes the update factor should be for FY 1988.	*(d) FY 1988 Update Recommendations.*—No provision.

II. MEDICARE PROVISIONS (PART A)—Continued

Item	Present Law
	(e) PPS-Exempt Update.—HHS has argued that a technical change in COBRA prohibits HHS from providing separate update factors for PPS and PPS-exempt hospitals.
	(f) Outlier Payments for Small Rural Hospitals and Sole Community Hospitals.—P.L. 98–21 provided for additional payments to PPS hospitals for "outliers"—cases with very long lengths of stay or extraordinarily high costs compared to most patients classified in the same DRG. The law requires that total outlier payments to all PPS hospitals be not less than 5 percent nor more than 6 percent of the total estimated Medicare prospective payments based on the DRG payment rates for the fiscal year. COBRA required the Secretary to report to Congress no later than January 1, 1987, on the impact of outlier and patient transfer policies on rural hospitals (particularly on rural hospitals with fewer than 100 beds).
	(g) Computing Urban and Rural Averages.—P.L. 98–21 provided that PPS hospitals are paid, in part, on the basis of Federal regional and national standardized amounts per discharge. The law requires the calculation of separate urban and rural standardized amounts for each of the nine census regions and for the nation. These standardized amounts represent the urban or rural operating cost per discharge in the base year cost data (1981), averaged across all hospitals in the region (or nation) and updated to the year of payment. In this calculation, the average operating cost per discharge for each hospital is treated the same as the cost per discharge of any other hospital, regardless of how many Medicare discharges the hospital had during the base year. This results in amounts that represent the operating cost per discharge for the average hospital (rather than the average Medicare discharge).

House Bill	Senate Amendment
(e) PPS-Exempt Update.—Provides that PPS-exempt hospitals and units may receive a separate update factor from PPS hospitals.	*(e) PPS-Exempt Update.*—No provision.
(f) Outlier Payments for Small Rural Hospitals and Sole Community Hospitals.—No provision.	*(f) Outlier Payments for Small Rural Hospitals and Sole Community Hospitals.*—Requires the total amount of outlier payments for sole community hospitals with average occupancies of 50 beds or fewer, and small rural hospitals (defined as a hospital in a rural area with fewer than 50 beds) to be not less than 5 percent nor more than 6 percent of the total payments based on DRG prospective payment rates projected or estimated to be made to such hospitals in a given year. Requires the Prospective Payment Assessment Commission to include in its annual report an analysis of the appropriate thresholds for outliers. Requires the Secretary to report to Congress no later than January 1, 1987, on the impact of outlier and patient transfer policies on sole community providers.
(g) Computing Urban and Rural Averages.—No provision.	*(g) Computing Urban and Rural Averages.*—The current formula used to calculate the separate average standardized payment amounts for urban and rural hospitals under PPS would be changed to be based on the number of patients discharged rather than the number of hospitals. This would result in amounts that represent the operating cost per discharge for the average patient as opposed to the average hospital.

Item	Present Law
	(h) Regional Referral Centers.—PPS hospitals may apply for designation as a regional referral center. In order to qualify, hospitals must meet criteria based on bed size and location, or criteria based on case-mix, admission volume, or patient referrals. Hospitals meeting these criteria are paid prospective payments based on the applicable urban payment rates, rather than the rural rates, as adjusted by the hospital's area wage index. Under regulations, once a hospital has achieved referral center status, it is paid at the applicable urban rate for a 3-year period.

House Bill	Senate Amendment
(h) Regional Referral Centers.—Extends the 3-year period granted for regional referral centers status to 4 years. After the 4th year, the hospital would be required to demonstrate that it continues to meet the criteria. See also item 7(b) (section 10207 of House bill).	***(h) Regional Referral Centers.***—Hospitals designated as regional referral centers as of the date of enactment shall retain that designation for all hospital cost reporting periods beginning before October 1, 1989. Provides that to be classified as a regional referral center, a rural hospital must (1) have a case mix equal to or greater than the median case mix for urban hospitals located in the same census region or the Nation (other than hospitals with approved teaching programs); (2) have 5,000 or more discharges a year (or in the case of a rural osteopathic hospital, meets the criterion established by the Secretary for the annual number of discharges); and (3) meet any other criteria established by the Secretary.
Effective date.—Applies rate of increase provision to hospital cost reporting periods beginning on or after October 1, 1986. For the Federal portion of the PPS payment rates, the rate of increase applies to discharges occurring on or after October 1, 1986. Conforming amendments are effective upon enactment. The promulgation of new rates provision requires the Secretary to republish the rate determination in the Federal Register within 30 days after the date of enactment of this Act but in no case later than October 1, 1986, without regard to the provisions of chapter 5 (Administrative Procedures) of title 5 (Government Organization and Employees), United States Code.	***Effective date.***—Applies rate of increase provision for PPS hospitals to discharges occurring on or after October 1, 1986 (for the Federal portion of the rate), and to discharges occurring in hospital cost reporting periods beginning on or after October 1, 1986 (for the hospital-specific portion of the rate). The rate of increase provision for PPS-exempt hospitals applies to hospital cost reporting periods beginning on or after October 1, 1986. The outlier payments for small rural hospitals and sole community hospitals provision (except the reports required from ProPAC or the Secretary) apply to discharges occurring after September 30, 1986, and before the first October 1 that is more than 270 days after the date on which the Secretary submits the report on outliers required by COBRA. The computing urban and rural averages provision is effective for discharges occurring on or after October 1, 1986. Hospitals which are regional referral centers on the date of enactment shall retain that status for cost reporting periods beginning on or after October 1, 1986, and before October 1, 1989.
Outlay effect (in millions): Fiscal years: 1987 ..... 180 1988 ..... −590 1989 ..... −750 3-year total ..... −1,160	***Outlay effect*** (in millions): Fiscal years: 1987 ..... 280 1988 ..... 370 1989 ..... 410 3-year total 1,060

Item	Present Law
3. Limitation on Payments for Capital-Related Costs for Inpatient Hospital Services of DRG Hospital Under Medicare (Section 10203 of House bill; Section 602 of Senate amendment)	The Social Security Amendments of 1983 (P. L. 98–21) established a prospective payment system (PPS) for making payments on a per discharge basis to hospitals for the operating costs of inpatient services provided to Medicare beneficiaries. Hospital capital-related costs for inpatient services (including depreciation, leases and rentals, interest, and a return on equity for proprietary hospitals) are excluded from the definition of operating cost for PPS and are reimbursed on a reasonable cost basis. This exclusion from the operating costs was to expire on October 1, 1986, but was extended until October 1, 1987, by the Urgent Supplemental Appropriations Act (P.L. 99–349). Current law provides that if Congress did not enact legislation by October 1, 1987, to include capital-related costs under PPS, Medicare payment for capital costs would be prohibited unless a State has a capital expenditure review agreement with the Secretary (under section 1122 of the Social Security Act) and the State has recommended approval of the specific capital expenditure.

House Bill	Senate Amendment
(a) Payment Limitation.—Requires the Secretary to cap the aggregate amount of PPS hospital capital-related payments. The cap for FY 1987 shall be the aggregate amount of hospital capital payments in 1986 as estimated by the Secretary plus 10 percent; for FY 1988 will be limited to the aggregate amount of hospital capital payments in FY 1986 plus 20 percent; and for FY 1989 will be limited to the aggregate amount of hospital capital payments in FY 1986 plus 30 percent. The FY 1986 base and the allowable costs reimbursed will be adjusted to reflect the phasing-out of payments for return on equity capital. The Secretary would be permitted to adjust the FY 1986 base in each of the following fiscal years based on the most recent available data.	*(a) Payment Limitation.*—Requires the Secretary to reduce the amounts for capital-related payments to PPS hospitals otherwise determined to be reasonable under current law, by 3 percent for cost reporting periods beginning on or after October 1, 1986, and before October 1, 1987; by 5 percent for cost reporting periods beginning on or after October 1, 1987, and before October 1, 1988; and by 6 percent for cost reporting periods beginning on or after October 1, 1988, and before October 1, 1989.
(b) Publication of Capital Reduction Percentage.—If the Secretary determines the target limits will be exceeded, the Secretary would be required to determine and publish the appropriate capital reduction percentage for each fiscal year required to maintain payments within the limit. The percent would be based upon the best available information before the beginning of the fiscal year involved. Requires the Secretary to publish in the Federal Register, no later than 30 days after the date of the enactment of this Act or, if earlier, by October 1, 1986, the capital reduction percentage for FY 1987. In promulgating the percentage for FY 1987, the provisions of chapter 5 (Administrative Procedures) of title 5 (Government Organization and Employees), United States Code, and of chapter 35 (Programs for Older Americans) of title 41 (Public Contracts), United States Code, shall not apply.	*(b) Publication of Capital Reduction Percentage.*—No provision.
(c) No Administrative or Judicial Review.—Prohibits administrative or judicial review of the capital reduction percentage.	*(c) No Administrative or Judicial Review.*—No provision.
(d) Interim and Final Payments.—Interim and final payments would be based on the percentage determined by the Secretary for portions of cost reporting periods occuring during the fiscal year.	*(d) Interim and Final Payments.*—No provision.

II. MEDICARE PROVISIONS (PART A)—Continued

Item	Present Law

House Bill	Senate Amendment
(e) Sole Community Hospitals.—No provison.	*(e) Sole Community Hospitals.*—Does not apply to the capital-related costs of sole community hospitals.
Effective date.—Applies to payments for capital-related costs attributable to portions of cost reporting periods occurring on or after October 1, 1986.	***Effective date.***—Cost reporting periods beginning on or after October 1, 1986, and before October 1, 1989.
Outlay effect (in millions):	***Outlay effect*** (in millions):
Fiscal years: 1987 ..... −155 1988 ..... −355 1989 ..... −590 3-year total ..... −1,100	Fiscal years: 1987 ..... −75 1988 ..... −205 1989 ..... −310 3-year total ..... −590

II. MEDICARE PROVISIONS (PART A)—Continued

Item	Present Law
4. Coverage of Hospitals in Puerto Rico Under DRG Prospective Payment System (Section 10204 of House bill)	Hospitals outside the 50 States and the District of Columbia are excluded by law from the prospective payment system (PPS) and are paid on the basis of reasonable costs, subject to the TEFRA rate of increase limits. The Secretary is required to report on methods of making payments to hospitals in the territories, including Puerto Rico, under a prospective payment system by April 1, 1984. The report has not yet been submitted.

House Bill	Senate Amendment
(a) In General.—Requires the Secretary to include eligible Puerto Rico hospitals in PPS. A hospital would be included in PPS if it is located in Puerto Rico and otherwise would be a PPS hospital if it were located in one of the 50 States. *(b) Payment Rate.*—Establishes payment amounts based on the sum of: (1) 75 percent of the Puerto Rico adjusted standardized payment amount; and (2) 25 percent of the national adjusted standardized payment amount. *(c) Base Used to Establish Puerto Rico Amount.*—Requires the Secretary to determine each hospital's target amount per discharge (under section 223) for hospital cost reporting periods beginning in FY 1986. *(d) Updating the Base.*—Requires the Secretary to increase the hospital's target amount per discharge by the applicable percentage increase for FY 1987. *(e) Standardizing the Amount.*—Requires the Secretary to standardize this amount by: (1) excluding an estimate of indirect medical education costs; (2) adjusting for variations in the Puerto Rico average hospital wage level; and (3) adjusting for variations in case mix among hospitals. *(f) Urban and Rural Hospitals.*—Requires the Secretary to calculate an average standardized amount for urban and for rural hospitals. *(g) Additional Reductions.*—Requires the Secretary to reduce the Puerto Rico standardized amounts by a proportion equal to the proportion (estimated by the Secretary) that outlier payments and disproportionate share payments represent of total Puerto Rico payments. *(h) Puerto Rico Prospective Payment Rate.*—Requires the Secretary to establish Puerto Rico urban and rural prospective payment rates for discharges within a DRG, equal to the urban or rural average standardized amount, with the additional reductions, multiplied by the weighting factor for that diagnosis related group.	No provision.

II. MEDICARE PROVISIONS (PART A)—Continued

Item	Present Law

House Bill	Senate Amendment
(i) Area Wage Adjustment.—Requires the Secretary to adjust the proportion (as estimated by the Secretary from time to time) of hospital costs attributable to wages and wage-related costs for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative wage level in the geographic area of the hospital compared to the Puerto Rican average hospital wage level. *(j) FY 1988 and Beyond.*—Requires the Secretary, for each hospital discharge after FY 1987, to compute the Puerto Rico adjusted DRG prospective payment rate by: (1) using the hospital's respective urban or rural average standardized amount as computed (in (f) above) for the previous fiscal year; (2) increasing this amount by the applicable percentage increase; and (3) by carrying out the steps described in (e) through (i) above. *(k) National Adjusted Standardized Payment Amount.*—Requires the Secretary to determine the average of the national adjusted standardized payment amounts for urban and for rural hospitals. *(l) Additional Payments.*—Provides for payment to Puerto Rico PPS hospitals in the same manner and to the same extent as they apply to other PPS hospitals for the following: outlier payments (except that the total amount of outlier payments to Puerto Rico hospitals may not be less than 5 percent nor more than 6 percent of the total payments projected or estimated to be made for Puerto Rico hospitals for discharges in that year), payments for indirect medical education costs (except that the calculation would conform to Puerto Rico's payment methodology), exceptions and adjustments, payments for costs of certified registered nurse anesthetists, and disproportionate share payments (except that the calculation would conform to Puerto Rico's payment methodology). *(m) Conforming Amendments.*—Provides for conforming amendments.	

II. MEDICARE PROVISIONS (PART A)—Continued

Item	Present Law

House Bill	Senate Amendment
(n) No Restandardization of National Levels to Reflect Inclusion of Puerto Rico.—Prohibits the Secretary from restandardizing or otherwise adjusting the national DRG prospective payment rates to take into account Puerto Rico's inclusion into the prospective payment system. ***Effective date.***—Applies to cost reporting periods beginning on or after October 1, 1986. The Secretary is required to issue regulations no later than October 1, 1986, to implement such amendments without regard to the provisions of chapter 5 (Administrative Procedures) of title 5 (Government Organization and Employees), United States Code. ***Outlay effect*** (in millions): Fiscal years: 1987 ..... 10 1988 ..... 15 1989 ..... 20 3-year total 45	

II. MEDICARE PROVISIONS (PART A)—Continued

Item	Present Law
5. Improving Quality of Care with Respect to Part A Services (Section 10205 of House bill; Sections 604 and 614 of Senate amendment)	*(a) Refinement of Prospective Payment System.*—Under Medicare's prospective payment system (PPS) hospitals are paid a predetermined rate based on a patient's diagnosis-related group (DRG) classification. The patient is classified into one of 468 DRGs based on his or her primary diagnosis, secondary diagnosis, primary procedure, age, and discharge status. Payment rates for each DRG reflect the average cost of providing care to patients classified in the DRG. *(b) Requiring Notice of Hospital Discharge Rights.*—On February 24, 1986, the Secretary instructed hospitals to provide Medicare inpatients with a notice explaining hospital discharge procedures under PPS and patients' rights to appeal discharge decisions. There is no statutory requirement that a statement of patient rights be distributed.

House Bill	Senate Amendment
(a) Refinement of Prospective Payment System.— *(1) Development of Legislative Proposal.*—Requires the Secretary to submit to Congress a specific legislative proposal to improve the classification and payment system under PPS (including the system for payment of outliers) in order to assure that the amount of payment per discharge approximates the cost of medically necessary care provided in an efficient manner for individual patients or classes of patients with similar conditions. *(2) Accounting for Severity of Illness.*—Requires the Secretary, in developing the proposal, to account for variations in severity of illness and case complexity which are not adequately accounted for by the current classification and payment system. *(3) Deadline.*—Requires the proposal be submitted to Congress by no later than 2 years after the date of enactment. ***Effective date.***—Enactment. ***Outlay effect*** (in millions):	*(a) Refinement of Prospective Payment System.*—No provision.
(b) Requiring Notice of Hospital Discharge Rights.—Requires hospitals to provide to each beneficiary (or to a legally responsible person acting on the beneficiary's behalf), at or about the time of the beneficiary's admission as an inpatient, a written statement which explains (1) the beneficiary's rights to Medicare benefits for inpatient hospital services and for post-hospital services, (2) the circumstances under which the beneficiary will and will not be liable for charges for a continued hospital stay, (3) the beneficiary's right to appeal denials of benefits for continued inpatient hospital services, including the practical steps to initiate such an appeal, and (4) the beneficiary's liability for payment for services if such a denial of benefits is upheld on appeal, and which provides any additional information as the Secretary may specify.	*(b) Requiring Notice of Hospital Discharge Rights.—Section 604(a).*—Similar provision.

Item	Present Law
	(c) Requiring Hospitals to Provide Discharge Planning Process.—By regulation, hospitals participating in Medicare must have a discharge planning program to facilitate the provision of follow-up care.

House Bill	Senate Amendment
Effective date.—Requires the Secretary to first prescribe the language no later than 6 months after the date of enactment. Applies to admissions to hospitals occurring on such date as the Secretary shall provide, but no later than 60 days after the date such language is first prescribed.	***Effective date.***—Requires the Secretary to first prescribe the language no later than 6 months after the date of enactment. Applies to admissions to hospitals occurring after such date as the Secretary shall provide, no later than 60 days after the date such language is first prescribed.
(c) Requiring Hospitals to Provide Discharge Planning Process.—	***(c) Requiring Hospitals to Provide Discharge Planning Process.—Section 604(b).***
(1) Requirement as a Condition of Participation.—Requires hospitals as a condition of participation for Medicare to have a discharge planning process.	(1) *Requirement as a Condition of Participation.*—Identical provision.
(2) Discharge Planning Process Defined.—Considers a discharge planning process sufficient if it is applicable to services furnished by the hospital to Medicare beneficiaries and if it meets the guidelines and standards established by the Secretary.	(2) *Discharge Planning Process Defined.*—Similar provision.
Requires the Secretary to develop these guidelines and standards in order to ensure a timely and smooth transition to the most appropriate type of setting for post-hospital or rehabilitative care. These guidelines and standards must include the following: (a) the hospital must identify, at an early stage of hospitalization, those patients who are likely to suffer adverse health consequences upon discharge in the absence of adequate discharge planning; (b) the hospital must provide a discharge planning evaluation for the identified patients and for other patients upon the request of the patient, patient's representative, or patient's physician; (c) any discharge planning evaluation must be made on a timely basis to ensure that appropriate arrangements for post-hospital care will be made before discharge and to avoid unnecessary delays in discharge; (d) a discharge planning evaluation must include an evaluation of a patient's likely	

II. MEDICARE PROVISIONS (PART A)—Continued

Item	Present Law

House Bill	Senate Amendment
need for appropriate post-hospital services and the availability of those services; (e) the discharge planning evaluation must be included in the patient's medical record for use in establishing an appropriate discharge plan and the results of the evaluation must be discussed with the patient (or the patient's representative); (f) upon the request of a patient's physician, the hospital must arrange for the development and initial implementation of a discharge plan for the patient; (g) any such discharge planning evaluation or discharge plan must be developed by, or under the supervision of, a registered professional nurse, social worker, or other appropriately qualified personnel.	
(3) Effect on Accreditation.—Provides that the requirement of discharge planning may not be satisfied by accreditation of the hospital accreditation body action pursuant to section 1865 of the Social Security Act unless the Secretary determines that the discharge planning standards of the accreditation body are at least equivalent to the standards required under this provision.	(3) Effect on Accreditation.—Similar provision.
Effective date.—Applies as of one year after the date of enactment.	*Effective date.*—Applies as of one year after the date of enactment.

Item	Present Law
	(d) Review of Standards for Medicare Conditions of Participation for Assuring Quality of Inpatient Hospital Services—For a hospital to be eligible for Medicare reimbursement, the hospital must be in compliance with Medicare's conditions of participation for hospitals as set forth in subchapter B of title 42 of the Code of Federal Regulations or must be accredited by a national accreditation body, such as the Joint Commission on Accreditation of Hospitals.
	(e) Study of Payment for Administratively Necessary Days.—Under Medicare's prospective payment system (PPS) hospitals are paid a predetermined rate based on a patient's diagnosis-related group (DRG) classification. The patient is classified into one of 468 DRGs based on his or her primary diagnosis, secondary diagnosis, primary procedure, age, and discharge status. Payment rates for each DRG reflect the average cost of providing care to patients classified in the DRG. No special provision is made for separate payment for "administratively necessary days." An administratively necessary day is a day of continued inpatient hospital stay necessitated by delays in obtaining placement of a patient in a skilled nursing facility.

House Bill	Senate Amendment
(d) Review of Standards for Medicare Conditions of Participation for Assuring Quality of Inpatient Hospital Services.—Requires the Secretary to arrange for a study of the adequacy of the standards used for hospitals, for the purposes of meeting Medicare's conditions of participation in assuring the quality of services furnished in hospitals. Requires the Secretary to report to Congress on the results of the study by no later than 2 years after the date of enactment. ***Effective date.***—Enactment.	*(d) Review of Standards for Medicare Conditions of Participation for Assuming Quality of Inpatient Hospital Services.*—No provision.
(e) Study of Payment for Administratively Necessary Days.— *(1) In General.*—Requires the Secretary to conduct a study to determine whether a payment should be made (in a budget-neutral way for PPS hospitals) to a hospital for administratively necessary days, separate from the DRG and outlier payments. *(2) Administratively Necessary Days Defined.*—Defines an "administratively necessary day" as a day of continued inpatient hospital stay, for a part A beneficiary, necessitated by a delay in obtaining placement for the individual in a skilled nursing facility. *(3) Consideration in Conducting Study.*—Requires the Secretary, in conducting the study, to consider the need for such a payment to minimize the disproportionate financial impact of current law on certain hospitals (or hospitals in certain locations) due to difficulties in arranging for appropriate post-hospital care such as difficulties resulting from a shortage of beds in skilled nursing facilities where those hospitals are located and difficulties resulting from the source of payment for such care.	*(e) Study of Payment for Administratively Necessary Days.*—No provision.

II. MEDICARE PROVISIONS (PART A)—Continued

Item	Present Law

House Bill	Senate Amendment
Requires the Secretary, in conducting the study, to consider the need for a payment to minimize the risk of inappropriate discharge to a non-institutional or inappropriate institutional setting of individuals who need post-hospital services in a skilled nursing facility. Requires the Secretary, in conducting the study, to consider the administrative mechanisms that can be used to prevent inappropriate payments for administratively necessary days. *(4) Report on Study.*—Requires the Secretary to report to Congress on the results of the study no later than January 1, 1988. ***Effective date.***—Enactment.	

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Item	Present Law
	(f) Continuing Waiver of Liability for SNFs, Home Health Agencies, and Hospice Programs.—Under waiver of liability, payment may be made for services which are not covered because they were not reasonable and necessary or were for custodial care if neither the beneficiary nor the provider knew or could reasonably have been expected to know that the services were not covered for these reasons. By regulation, a home health agency is presumed to meet this test if its denial rate on claims for services is 2.5 percent or less. A SNF is presumed to meet the test if its denial rate is 5.0 percent or less. Hospice providers are not eligible for a favorable presumption. Final regulations published February 21, 1986, eliminated the favorable presumption of the waiver of liability. Payment for noncovered services would have continued on a case-by-case basis. However, COBRA maintained the favorable presumption criteria for SNFs and home health agencies. As a result of the law, the favorable presumption will be continued until October 7, 1988, for SNF services. The favorable presumption for home health services will be continued until 12 months after claims processing for home health agencies has been consolidated under 10 regional intermediaries. ***(g) Extension of Waiver of Liability Provisions to Certain Coverage Denials for Home Health Services.***—Beneficiaries who are homebound and require skilled nursing services on an intermittent basis or physical, occupational, or speech therapy are eligible for home health services. Program guidelines provide fiscal intermediaries and home health agencies with information and guidance about coverage determinations for patients who are "homebound" or whether skilled nursing and home health aide services are "intermittent." The current waiver of liability protection does not apply to noncovered home health services if the reason for the

House Bill	Senate Amendment
(f) Continuing Waiver of Liability for SNFs, Home Health Agencies, and Hospice Programs.—Continues the favorable presumption of waiver of liability for SNFs and home health agencies, and establishes a favorable presumption for hospices having 2.5 percent or fewer claims denied on the basis of care not being reasonable and necessary or determined to be custodial in nature. Requires the Secretary to report annually to Congress on (1) the frequency and distribution of denials because care was not reasonable and necessary or was custodial; and (2) other information needed to evaluate the appropriateness of denial rates established for a favorable presumption. ***Effective date.***—For hospices, effective for care furnished on or after the first day of the first month that begins at least 6 months after date of enactment and before October 1, 1989. For SNFs and home health agencies, effective for services furnished on or after date of enactment and before October 1, 1989.	***(f) Continuing Waiver for Liability for SNFs, Home Health Agencies, and Hospice Programs.***—No provision.
(g) Extension of Waiver of Liability Provisions to Certain Coverage Denials for Home Health Services.—Extends waiver of liability for home health agencies to coverage decisions about whether a patient is homebound or whether a person needs skilled nursing care on an intermittent basis or physical, speech, or occupational therapy. A favorable presumption regarding the waiver of liability for denials on these grounds would be available for home health agencies which (1) comply with requirements on timely submittal of bills for payment and medical documentation, (2) promptly notify patients where it is determined that a patient is	***(g) Extension of Waiver of Liability Provisions to Certain Coverage Denials for Home Health Services.—Section 614.***—Extends waiver of liability protection for home health agencies to coverage decisions about whether a patient is homebound or whether a person needs skilled nursing care on an intermittent basis. Requires the Secretary not later than July 1, 1987, to publish final regulations specifying criteria used as of Jan. 1, 1986, in determining coverage for patients who are homebound or who require skilled nursing care on an intermittent basis.

Item	Present Law
	denial is because the patient was determined not to be confined to his home or not to need skilled nursing care on other than an intermittent basis. Denials of these kinds are often referred to as technical denials.
	(h) Development of Uniform Needs Assessment Instrument.—There is no comparable requirement in current law.

House Bill	Senate Amendment
being or will be furnished items or services which are excluded from coverage, and (3) have no more than 2.5 percent of claims submitted during the previous quarter denied on the basis of home bound or intermittent care requirements.	
Effective date.—Effective for services furnished on or after the first day of the first month that begins more than 90 days after date of enactment, with the favorable presumption provisions for denials based on homebound and intermittent coverage decisions effective through September 30, 1989.	*Effective date.*—Effective for coverage denials occurring on or after July 1, 1987.
(h) Development of Uniform Needs Assessment Instrument.—	*(h) Development of Uniform Need Assessment Instrument.*—No provision.
(1) Development.—Requires the Secretary to develop a uniform need assessment instrument that (A) evaluates the functional capacity of an individual, the nursing and other care requirements of the individual to meet health care needs and to assist with functional incapacities, and the social and familial resources available to the individual to meet those requirements; and (B) can be used by discharge planners, hospitals, nursing facilities, other health care providers, and fiscal intermediaries in evaluating an individual's need for post-hospital extended care services, home health services, and long-term care services of a health related or supportive nature. The Secretary may develop more than one such instrument for use in different situations.	
(2) Advisory Panel.—Requires the Secretary to develop the instrument in consultation with an advisory panel appointed by the Secretary. The panel is to include experts in the delivery of post-hospital extended care services, home health services, and long-term care services, and is to include representatives of hospitals, physicians, skilled nursing facilities, home health agencies, long-term care providers, fiscal intermediaries, and Medicare beneficiaries.	

Item	Present Law
	(i) Expedited Review by Fiscal Intermediaries—Claims for skilled nursing facility, home health services, and hospice care services generally are reviewed on a retrospective basis after the services are provided. Standards for timeliness in claims submission and review are not provided in present law.
	(j) Including in Annual Reports on Prospective Payment System Information on Quality of Post-Hospital Care.—The Secretary is required to report on the impact of the prospective payment methodology for inpatient hospital services, due annually at the end of each year for 1984 through 1987.

House Bill	Senate Amendment
(3) Report of Instrument.—Requires the Secretary to report to Congress, no later than 1 year after the date of enactment, on the instrument or instruments developed. The report is required to include an evaluation of the advantages and disadvantages of using the instrument or instruments as the basis for determining whether payment should be made for post-hospital extended care services and home health services provided to Medicare beneficiaries.	
Effective date.—Enactment.	
(i) Expedited Review by Fiscal Intermediaries.—Requires the Secretary to develop procedures to expedite the determination of whether initial claims submitted for skilled nursing facility, home health services, and hospice care services provided (or to be provided) to an individual may be reimbursed by Medicare, in order to minimize the time between when the provider first provides the services to the individual and when the provider first receives notice of an initial determination on whether Medicare will pay for some or all of the provided services.	***(i) Expedited Review by Fiscal Intermediaries.***—No provision.
Effective date.—Requires the Secretary to provide for the expedited procedures no later than one year after the date of enactment.	
(j) Including in Annual Reports on Prospective Payment System Information on Quality of Post-Hospital Care.—	***(j) Including in Annual Reports on Prospective Payment System Information on Quality of Post-Hospital Care.***—No provision.
(1) Additional Reports.—Extends the requirement for annual reports through 1989.	

Item	Present Law
	(k) Prior Authorization Demonstration Project.—Medicare fiscal intermediaries have responsibility for deciding whether payment will be made for services provided by home health agencies and SNFs. Generally, these payment decisions are made on a retrospective basis after services are provided.

House Bill	Senate Amendment
(2) Information on Quality of Post-Hospital Care.—Requires the annual impact reports to include (A) an evaluation of the adequacy of the procedures for assuring quality of Medicare post-hospital services; (B) an assessment of problems that have prevented groups of Medicare beneficiaries (including those eligible for Medicaid) from receiving appropriate Medicare post-hospital services; and (C) information on Medicare reconsiderations and appeals for payment for post-hospital services.	
Effective date.—Enactment. Applies to reports for years beginning with 1986.	
(k) Prior Authorization Demonstration Project.—Requires the Secretary of HHS to conduct a demonstration program concerning prior authorization for Medicare SNF and home health services. Requires the demonstration to include at least four projects implemented not later than July 1, 1987. Requires the Secretary to waive compliance with Medicare requirements to the extent and for the period the Secretary finds necessary to conduct the demonstration.	***(k) Prior Authorization Demonstration Project.—Section 604(c).***—Requires the Secretary to develop and carry out a demonstration project to determine whether prior and concurrent authorization for SNF and home health services, when used in place of the current waiver of liability policy, will protect beneficiaries against liabilities incurred as a result of claim denials. Requires the Secretary to monitor the acceptance of beneficiaries by providers to ensure that their placement is not delayed until the results of prior and concurrent review are known. Requires that the demonstration be initiated not later than January 1, 1987, and continue for not more than 2 years.
Requires that the demonstration be developed in consultation with an advisory panel that includes experts in the delivery of SNF services, home health services, and long-term care services and include representatives of hospitals, physicians, SNFs, home health agencies, long-term care providers, fiscal intermediaries, and Medicare beneficiaries.	Authorizes the Secretary to require providers participating in the demonstration to submit such information as the Secretary determines is necessary to evaluate the project. Requires the Secretary to report to Congress on the results of the evaluation not later than April 2, 1988.

II. MEDICARE PROVISIONS (PART A)—Continued

Item	Present Law

House Bill	Senate Amendment
Requires the Secretary to evaluate the demonstration and report to Congress on the evaluation no later than January 1, 1989. Requires the Secretary to address the following issues in the evaluation: (1) the administrative and program costs for prior authorization in comparison to costs under the current system of retroactive review, including costs for uncovered services paid under the waiver of liability which would not be incurred under prior authorization; (2) impact of prior authorization on access and availability of SNF and home health services in comparison to the current system and on timely discharge of hospital inpatients; and (3) accuracy and associated cost savings of payment determinations and rates of claim reversals under prior authorization versus the current system.	
Specifies that funding for the demonstration would come from the Federal Hospital Insurance Trust Fund.	
Effective date.—Enactment.	***Effective date.***—Enactment.
Total outlay effect (in millions):	***Total outlay effect*** (in millions):
Fiscal Years: 1987 ..... 58 1988 ..... 70 1989 ..... 167 3-year total 295	Fiscal years: 1987 ..... 43 1988 ..... 50 1989 ..... 57 3-year total 150

II. MEDICARE PROVISIONS (PART A)—Continued

Item	Present Law
6. Off-Budget Treatment of Federal Hospital Insurance Trust Fund in Fiscal Year 1987 (Section 10206 of House bill)	Federal Hospital Insurance (HI) Trust Fund receipts and disbursements are included in the unified budget of the U.S. Government, but are scheduled to be removed from the unified budget in FY 1993. The Balanced Budget and Emergency Deficit Control Act of 1985 (P.L. 99–177) removed the receipts and disbursements of the Social Security Trust Funds (the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund, known as OASDI) from the unified budget effective for FY 1986. The disbursements and expenditures of the Social Security Trust Funds, however, are included for purposes of determining whether the deficit exceeds the "maximum deficit amount" targets set in the Gramm-Rudman-Hollings legislation.

House Bill	Senate Amendment
Removes the receipts and disbursements of the Federal Hospital Insurance (HI) Trust Fund, from the unified budget of the U.S. Government. As under OASDI, the disbursements and expenditures of the HI trust fund would be included for purposes of determining whether the deficit exceeds the "maximum deficit amount" targets set in the Gramm-Rudman-Hollings legislation, and would be exempt from any general budget limitation on outlays imposed by statute.	No provision.
Effective date.—Applies to fiscal years beginning after September 30, 1986, and end before October 1, 1992.	
Outlay effect. None.	

Item	Present Law
7. Technical Amendments and Miscellaneous Provisions Relating to Part A (Section 10207 of House bill)	***(a) One-Year Extension of Pass-Through for Costs of Certified Registered Nurse Anesthetists.***—See item (section 4524 of House bill) for this description. ***(b) Extended Designation Period for Regional Referral Centers.***—See item 2 (section 10202 of House bill; section 601 of Senate amendment) for this description. ***(c) Temporary Waiver of Inpatient Limitations for the Connecticut Hospice, Inc.***—Medicare-certified hospices are required to maintain no more than 20 percent of total days as inpatient days. Connecticut Hospice, Inc., currently has waivers for a number of Medicare requirements. These waivers will no longer be in effect on October 1, 1986. ***(d) Massachusetts Medicare Repayment.***—Massachusetts operated a Statewide hospital demonstration project from October 1, 1982, through June 30, 1986. The Secretary is required to judge the effectiveness of the demonstration to ensure that Medicare expenditures under the demonstration are not greater than they would have been under Medicare regular reimbursement rules. The Secretary has determined that Medicare part A overpayments were made during the first two years of the Massachusetts waiver and has established a repayment schedule for the alleged overpayments. ***(e) Part A COBRA Technical and Other Miscellaneous Corrections.***—Current law contains a number of technical errors.

House Bill	Senate Amendment
(a) One-Year Extension of Pass-Through for Costs of Certified Registered Nurse Anesthetists.—See item 18 (section 4524 of House bill) for this description.	*(a) One-Year Extension of Pass-Through for Costs of Certified Registered Nurse Anesthetists.*—No provision.
(b) Extended Designation Period for Regional Referral Centers.—See item 2(h) (section 10202 of House bill; section 601 of Senate amendment) for this description.	*(b) Extended Designation Period for Regional Referral Centers.*—See item 2 (Section 10202 of House bill; Section 601 of Senate amendment) for this description.
(c) Temporary Waiver of Inpatient Limitations for the Connecticut Hospice, Inc.—Waives Connecticut Hospice, Inc., from the 80/20 inpatient/home care day requirement for two years, provided they do not exceed 50 percent of total days as inpatient days.	*(c) Temporary Waiver of Inpatient Limitations for the Connecticut Hospice, Inc.*—No provision.
(d) Massachusetts Medicare Repayment.—Prohibits the Secretary from recouping or otherwise reducing payments to Massachusetts hospitals on or after the date of enactment of this section and before January 1, 1988.	*(d) Massachusetts Medicare Repayment.*—No provision.
(e) Part A COBRA Technical and Other Miscellaneous Corrections.—Corrects technical errors as follows: (1) corrects and clarifies a section regarding payments under the disproportionate share provision; (2) corrects and clarifies a section regarding payments under the indirect teaching adjustment; (3) clarifies that all hospitals which have a Medicare provider agreement would have to abide by the emergency care requirements; (4) allows SNFs to make election to be paid on a prospective payment basis based on their cost reporting periods rather than on a Federal fiscal year basis; (5) clarifies that the Hospital Insurance tax on State and local government does not apply to certain election workers (Note: see Revenue Provisions, item 1 (section 661 of Senate amendment) for a description of a similar provision.); and (6) makes other miscellaneous corrections to COBRA and related laws.	*(e) Part A COBRA Technical and Other Miscellaneous Corrections.*—No provision. Note: See Revenue provisions, item 1 (Section 661 of Senate amendment) for a description of a similar provision regarding election worker exemption from Hospital Insurance tax.

II. MEDICARE PROVISIONS (PART A)—Continued

Item	Present Law

House Bill	Senate Amendment
Effective date.—Enactment, except the technical corrections are effective as if they had been included in the enactment of the laws they amend. ***Outlay effect.***—None.	

Item	Present Law
8. Medicare Payments to Large Rural Hospitals Serving a Disproportionate Share of Low-Income Patients (Section of Senate Amendment)	COBRA provided that additional payments will be made—for discharges occuring on or after May 1, 1986 but before October 1, 1988—to PPS hospitals that serve a disproportionate share of low-income patients. For urban PPS hospitals with 100 or more beds having a percentage of low-income patients of at least 15 percent, the Federal portion of the PPS payment is increased by 2.5 percent plus half the difference between 15 percent and the hospital's percentage of low-income patients, not to exceed 15 percent. For urban hospitals with less than 100 beds having a percentage of low-income patients of at least 40 percent, the Federal portion of the PPS payment is increased by 5 percent. For rural hospitals having a percentage of low-income patients of at least 45 percent, the Federal portion of the PPS payment is increased by 4 percent. The percentage of low-income patients is defined as the hospital's total number of medicare-covered inpatient days attributable to Medicare patients who are eligible for Federal Supplemental Security Income benefits, divided by the total number of Medicare-covered patient days, plus the number of Medicaid-covered patient days divided by the hospital's total patient days. Payments are also made to urban hospitals with 100 or more beds which demonstrate that more than 30 percent of their inpatient revenues are derived from State and local government payments for indigent care (excluding payments under Medicare and Medicaid).

House Bill	Senate Amendment
No provision.	Allows the Secretary to establish a separate threshold percentage of low-income patients required for rural hospitals with 300 or more beds to qualify for Medicare disproportionate share payments. These hospitals would have the Federal portion of the PPS payment increased by the same formula currently used for urban hospitals with 100 or more beds (2.5 percent plus half the difference between 15 percent and the hospital's percentage of low-income patients, not to exceed 15 percent). Rural hospitals with less than 300 beds would continue to be required to have a percentage of low-income patients of at least 45 percent in order to qualify for Medicare disproportionate share payments. These hospitals would continue to have their payment increased by 4 percent. *Effective date.*—Applies to discharges occurring on or after October 1, 1986. *Outlay Effect.*—None.

II. MEDICARE PROVISIONS (PARTS A AND B)—Continued

Item	Present Law
9. Elimination of Periodic Interim Payments (PIP) for Prospective Payment System (PPS) Hospitals and Prompt Payment for Medicare Providers (Section 10221 of House bill; Section 612 of Senate amendment)	Current law does not specifically provide for periodic interim payments (PIP); however, regulations allow hospitals, skilled nursing facilities, and home health agencies which meet certain requirements to receive Medicare periodic interim payments (PIP) every 2 weeks, based on estimated annual costs without regard to the submission of individual bills. At the end of the year, a settlement is made. In final regulations published on August 15, 1986, the Department of Health and Human Services eliminated PIP for most PPS and PPS-exempt hospitals, effective July 1, 1987. The Health Care Financing Administration recently issued guidelines requiring each part A intermediary and part B carrier to process at least 95 percent of "clean" Medicare claims within 27 days of receipt. "Clean" Medicare claims are those not requiring development for payment safeguard activities or additional information. The guidelines apply to Medicare claims submitted by beneficiaries, physicians, providers, and suppliers.

House Bill	Senate Amendment
(a) Elimination of PIP for PPS Hospitals.—Eliminates periodic interim payments for inpatient services in PPS hospitals (including distinct psychiatric or rehabilitation units of PPS hospitals) except for disproportionate share hospitals, sole community hospitals, and hospitals receiving Medicare payment under a State hospital reimbursement system if payment on a PIP basis is an integral part of the reimbursement system. Eligible PPS-exempt hospitals and other cost-based providers (i.e., outpatient hospitals skilled nursing facilities, and home health agencies) may continue to receive periodic interim payments. If a PPS hospital has significant cash flow problems resulting from operations of its intermediary or from unusual circumstances of the hospital's operation, the Secretary is required to make available accelerated payments.	*(a) Elimination of PIP for PPS Hospitals.*—Eliminates periodic interim payments for inpatient services in PPS hospitals (including distinct psychiatric or rehabilitation units of PPS hospitals). The elimination of PIP for PPS hospitals would be delayed until the intermediary demonstrates that it has complied with the prompt payment requirement for at least three consecutive months. If the intermediary fails to meet the prompt payment requirements for three consecutive months, all the PPS hospitals it serves may choose to be placed on PIP. Eligible PPS-exempt hospitals and other cost-based providers (i.e., skilled nursing facilities and home health agencies) may continue to receive periodic interim payments.
(b) Part A Prompt Payment.—Provides (for Medicare claims not paid on a PIP basis) that if payment is not made by a part A intermediary by the 22nd calendar day after the day on which a clean claim is received, interest would accrue beginning on the day after the day on which payment was due and ending on the day payment is made. Intermediaries are required to notify the beneficiary or provider who submits a claim, within 22 calendar days after the date on which a claim is received, of any defect, impropriety, or circumstance that prevents the claim from being treated as a clean claim. If such notice is not provided on a timely basis and the claim is eventually paid, interest would accrue beginning on the day after the day the notice is required and ending on the day payment is made or the day notice is provided, whichever is earlier.	*(b) Part A Prompt Payment.*—Requires (for Medicare claims not paid on a PIP basis) payment to be made by a part A intermediary for at least 95 percent of all Medicare clean claims by the applicable number of calendar days after the day on which a clean claim is received. In FY 1987, the applicable number of calendar days is 27, in FY 1988 it is 26, in FY 1989 it is 25, and in FY 1990 and thereafter, it is 24. For clean claims not paid on a PIP basis, if payment is not made by the applicable number of days after the date on which a clean claim is received, interest would be paid beginning on the day after the date on which payment was due, and ending on the date payment is made.

II. MEDICARE PROVISIONS (PARTS A AND B)—Continued

Item	Present Law

House Bill	Senate Amendment
(c) Part B Prompt Payment.—Provides (for Medicare claims not paid on the PIP basis) that if payment is not made by a part B carrier by the 22nd calendar day (or by the 11th calendar day in the case of a participating physician or supplier) after the date on which a clean claim is received, interest would accrue beginning on the day after the day on which payment was due and ending on the day payment is made. Part B carriers are required to notify the beneficiary, physician, or supplier who submits a claim, within 22 calendar days (or by the 11th calendar day in the case of a participating physician or supplier) after the date on which a claim is received of any defect, impropriety, or circumstance that prevents the claim from being treated as a clean claim. If such notice is not provided on a timely basis and the claim is eventually paid, interest would accrue beginning on the day after the date the notice is required and ending on the day payment is made or the day notice is provided, whichever is earlier.	*(c) Part B Prompt Payment.*—Provides (for Medicare claims not paid on a PIP basis) that if payment is not made by a part B carrier for at least 95 percent of all Medicare clean claims by the applicable number of calendar days after the day on which a clean claim is received, interest would be paid beginning on the day after the day on which payment was due and ending on the day payment is made.
(d) Interest Rate.—Interest under this provision is paid at the rate used for purposes of section 3902(a) (Interest Penalties) of title 31 (Money and Finance), United States Code.	*(d) Interest Rate.*—Similar provision.
(e) Federal Administrative Costs.—Carriers and intermediaries will be reimbursed for interest payments from amounts made available for Federal administrative costs to carry out this provision (other than the amounts made available for intermediary and carrier agreements).	*(e) Federal Administrative Costs.*—No provision.
(f) Definition of "Clean" Claim.—A "clean" claim is defined as a claim that has no defect or impropriety (including missing required substantiating documentation) or particular circumstances requiring special treatment that prevents timely payment.	*(f) Definition of "Clean" Claim.*—A "clean" claim is defined as a claim which meets Medicare requirements for payment under part A or part B respectively. In addition, in order for a part A claim to be a clean claim it must meet the requirements of section 1814(a)(1) (which defines a Medicare claim).
(g) Timely Amendments to Agreements and Regulations.—No provision.	*(g) Timely Amendments to Agreements and Regulations.*—Requires the Secretary to provide for timely amendments to intermediary and carrier agreements and regulations to the extent necessary to implement these provisions.

II. MEDICARE PROVISIONS (PARTS A AND B)—Continued

Item	Present Law

House Bill	Senate Amendment
Effective date.—Applies PIP provision for discharges occurring on or after August 1, 1987. The timely payment for part A claims provision applies to claims received on or after October 1, 1987. The prompt payment for Medicare physicians and suppliers provision applies to claims received on or after October 1, 1987.	***Effective date.***—Applies to claims received on or after October 1, 1986, except that the interest penalties apply to claims received on or after April 1, 1987.
Outlay effect (in millions):	***Outlay effect*** (in millions):
Fiscal years:	Fiscal years:
1987 905	1987 405
1988 1,380	1988 210
1989 260	1989 250
3-year total 2,545	3-year total 865

Item	Present Law
10. Health Maintenance Organization Amendments (Sections 10222 and 4510 of House bill)	Section 1876 of the Social Security Act, as amended by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), provides for Medicare payments to Health Maintenance Organizations (HMOs) and Competitive Medical Plans (CMPs) on either a risk or a cost contracting basis. In general, risk contracting plans are financially responsible for the cost of all benefits their enrollees would otherwise be eligible for under Medicare while enrolled in these plans. *(2) Two for One Rule.*—Section 114(c)(2) of TEFRA provides that HMOs with enrolled individuals under an existing cost-contract can convert such individuals to enrollment under a risk contract. However, the plan must enroll two new Medicare enrollees under the risk contract for each enrollee converted from the cost to the risk contract. This provision is known as the "two for one" rule. *(b) Explanation of Enrollee Rights.*—Each HMO and CMP must meet certain requirements to be eligible to contract with the Secretary to enroll Medicare members. These requirements include accepting financial responsibility for contracted services and providing for meaningful grievance procedures. The enrolling member of a risk contracting plan accepts that, except for emergency and out-of-area care, neither the plan nor Medicare has financial responsibility for services not rendered by or through the contracting plan. *(c) Restriction on Waivers of 50 Percent Medicare and Medicaid Enrollment.*—Each Medicare contracting HMO and CMP must have at least half of their membership composed of enrollees that are not entitled to benefits under either Medicare or Medicaid. The Secretary can waive this requirement only if circumstances warrant such waiver and the organization is making reasonable efforts to enroll individuals not entitled to Medicare or Medicaid.

House Bill	Senate Amendment
	No provision.
(a) Two for One Rule.— ***Section 10222.***—Amends TEFRA such that the "two for one rule" does not apply for current nonrisk HMO Medicare enrollees for months beginning with April 1987.	
Section 4510.—No provision.	
(b) Explanation of Enrollee Rights.— ***Section 10222.***—Requires HMOs and CMPs contracting on either a risk or cost basis to provide each enrollee at the time of enrollment, and not less than annually thereafter, an explanation of the enrollee's rights, including enrollee's rights to benefits from the organization, restrictions on Medicare payments for services provided other than by or through the organization, out-of-area coverage, coverage of emergency services, and appeal rights of enrollees.	
Section 4510.—No provision.	
(c) Restriction on Waivers of 50 Percent Medicare and Medicaid Enrollment.— ***Section 10222.***— (1) Limits the Secretary's authority to issue new waivers of the 50 percent rule to plans with service areas that include populations more than half of which are entitled to either Medicare or Medicaid. (2) Provides that, if an eligible organization fails to comply with the requirements for a waiver, the Secretary may suspend enrollment of Medicare enrollees by the organization. (3) Provides that, in the case of organizations that currently have a waiver but that do not meet the requirements for such waiver as amended by this section, the Secretary is given	

II. MEDICARE PROVISIONS (PARTS A AND B)—Continued

Item	Present Law
	(d) Prompt Payment of Claims.—Each HMO and CMP is financially responsible for the cost of benefits used by its enrollees, whether provided directly or under arrangement.
	(e) Financial Disclosure.—Each HMO and CMP is required to comply with Section 1318 of the Public Health Service Act (relating to financial disclosure).

House Bill	Senate Amendment
the authority to suspend enrollments under Medicare if the organization does not meet scheduled enrollment goals approved by the Secretary.	
Section 4510.— (1) Similar provision.	
(2) Provides that, if an eligible organization fails to comply with the requirements for a waiver, the Secretary may provide for a suspension of Medicare payments to the organization.	
(3) Provides that, in the case of organizations that currently have a waiver but that do not meet the requirements for such waiver as amended by this section, the Secretary is given the authority to suspend payments under Medicare.	
(d) Prompt Payment of Claims.— ***Section 10222.***—Requires that risk contracting organizations must provide for payment of claims submitted for covered services and supplies furnished to their enrollees by physicians, providers and suppliers not having a contractual arrangement with the organization within the same time limits for prompt payment that apply to Medicare carriers and fiscal intermediaries. If, after notice and opportunity for a hearing, an organization fails to make prompt payments, the Secretary may provide for direct payment of amount owed and then deduct the amount of such payments (and amounts incurred by the Secretary in making such payments) from payment otherwise made to such organizations.	
Section 4510.—No provision.	
(e) Financial Disclosure.— ***Section 10222.***—Requires that HMOs and CMPs supply, on request of the Secretary and according to regulations specified by the Secretary, information as to ownership of subcontractors with whom the organization had business transactions in excess of $25,000 during the preceding 12 months, and complete information regarding significant business transactions between organizations and wholely owned subcontractors or suppliers during the 5-year period preceding the date of such request. The organi-	

Item	Present Law
	(f) Civil Monetary Penalties.—Medicare contracts with HMOs and CMOs are automatically annually renewable, unless the Secretary determines that the organization has failed to meet its contractual obligations. The Secretary may terminate such contracts at any time if is found (after appropriate notice and opportunity for hearing) that the organization has substantially failed to carry out the terms of the contractual requirements.
	(g) Study of AAPCC and ACR.—Reimbursement of risk contracting HMOs and CMPs is determined based on estimates of the average adjusted per capita cost (AAPCC) and the adjusted community rate (ACR).
	(h) Allowing Medicare Beneficiaries to Disenroll at a Local Social Security Office.—No provision.

House Bill	Senate Amendment
zation is required to notify the Secretary of loans or other special financial arrangements between the organization and its subcontractors, affiliates, and related parties.	
Section 4510.—No provision.	
(f) Civil Money Penalties.— *Section 10222.*—Provides that any risk-contracting organization that fails substantially to provide any medically necessary items and services that are required to be provided under such contract, is subject to a civil money penalty of not more than $2,000 for each such failure if the failure has adversely affected (or has the likelihood of adversely affecting) individuals enrolled under such contract. Such penalties are subject to the requirements generally applicable to civil money penalties under Section 1128A of the Social Security Act (except for subsection (a)).	
Section 4510.—No provision.	
(g) Study of AAPCC and ACR.— *Section 10222.*—Requires the Secretary to provide, through a contract with an appropriate organization, for a study of the methods by which the AAPCC and the ACR can be refined to more accurately reflect the cost of providing care to different classes of patients, and to submit to Congress not later than January 1, 1988 specific legislative recommendations concerning the methods by which these measures can be refined.	
(h) Allowing Medicare Beneficiaries to Disenroll at a Local Social Security Office.— *Section 10222.*—Requires the Secretary to provide that beneficiaries may disenroll from HMOs and CMPs at any local office of the Social Security Administration on or after June 1, 1987.	
Section 4510.—No provision.	
Effective date.—Section 10222.—Enactment except for the following:	
(b) January 1, 1987.	

II. MEDICARE PROVISIONS (PARTS A AND B)—Continued

Item	Present Law
11. Provisions Relating to Improvement of Quality of Care (Section 10223 of House bill; Sections 614 and 615 of Senate amendment)	*(a) Provider Representation of Beneficiaries on Appeals and Appeal of Technical Denials.*—If a beneficiary disagrees with a payment denial for services provided under Medicare Part A, he or she is entitled to appeal the determination. In the past, beneficaries have been permitted to be represented in their appeals by the provider who furnished the services in question. However, in April, 1984, HCFA issued an intermediary manual instruction prohibiting such representation. HCFA also has prohibited appeals of "technical" denials, such as homebound and intermittent care requirements for home health services.

House Bill	Senate Amendment
(c) Except for subsection (3) relating to current waivers, applies to modifications and waivers granted after enactment. (d) Applies to services furnished on or after July 1, 1987. (e) Applies to contracts as of January 1, 1987. ***Section 4510.***—Except for subsection (3) relating to current waivers, applies to modifications and waivers granted after enactment. ***Outlay effect*** (in millions): ***Section 10222.***— Fiscal years: 1987 ..... 25 1988 ..... 50 1989 ..... 45 3-year total ..... 120 ***Section 4510.***—None.	
(a) Provider Representation of Beneficiaries on Appeals and Appeal of Technical Denials.—Allows providers to represent beneficiaries on appeals, but prohibits representation by a provider with respect to issues described in section 1879(a)(2) of the Social Security Act unless the provider has waived any rights for payment from the beneficiary for services involved in the appeal. Provides beneficiaries the right to appeal any payment denial for benefits under part A or part B home health services. ***Effective date.***—Enactment.	***(a) Provider Representation of Beneficiaries on Appeals and Appeal of Technical Denials.***—Similar provision, except prohibits provider representing beneficiary from imposing any financial liability on the beneficiary in connection with representation. Also prohibits costs incurred by provider for representing a beneficiary in an unsuccessful appeal from being allowed as reasonable costs. Provides beneficiaries the right to appeal payment denials for home health services that do not meet the "intermittent or home bound" criteria. ***Effective date.***—For provider representation provisions, effective on enactment. For technical denials provisions, effective for coverage denials occurring on or after July 1, 1987.

Item	Present Law
	(b) Prohibition of Certain Physician Incentive Plans.—Section 1866(d) of the Social Security Act provides for Medicare payments to most hospitals on a prospective basis. These PPS hospitals are responsible for the costs of all medically necessary part A inpatient services provided to Medicare beneficiaries during their inpatient stay. Section 1876 of the Social Security Act, as amended by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), provides for Medicare payments to Health Maintenance Organizations (HMOs) and Competitive Medical Plans (CMPs) on either a risk or a cost contracting basis. In general, risk contracting plans are financially responsible for the cost of all benefits their enrollees would otherwise be eligible for under Medicare while enrolled in these plans.

House Bill	Senate Amendment
(b) Prohibition of Certain Physician Incentive Plans.—	*(b) Prohibition of Certain Physician Incentive Plans.*—No provision.
(1) Prohibition of Incentive Payments.—Prohibits a hospital or risk-contracting HMO or CMP from knowingly making incentive payments to a physician as an inducement to reduce or limit services provided to Medicare beneficiaries who are under the direct care of the physician. With respect to HMOs and CMPs, the prohibition applies to Medicare enrollees of such entities. Hospitals and risk-contracting HMOs and CMPs who knowingly make such payments are subject to civil money penalties of $2,000 for each such individual with respect to whom the payments are made, in addition to any other penalties that may be prescribed by law. Any physician who knowingly accepts such incentive payments is subject to a civil money penalty of $2,000 for each such individual with respect to whom such payments are made, in addition to any other penalties prescribed by law.	
(2) Study of Incentive Arrangements.—Requires the Secretary to conduct a study of incentive arrangements offered to physicians by HMOs and CMPs, and to report the findings to Congress no later than April 1, 1987. The report shall include recommendations for providing exceptions for such organizations from the prohibition specified under (1) for incentive payments that encourage efficiency in the utilization of services but do not have a substantial potential for an adverse effect on quality.	
Effective date.—The prohibition and civil money penalty provisions apply to payments made by hospitals occurring more than 6 months after enactment, and to payments made by risk contracting plans on or after January 1, 1988.	

II. MEDICARE PROVISIONS (PARTS A AND B)—Continued

Item	Present Law
	(c) Study to Develop a Strategy for Quality Review and Assurance.—No provision.

House Bill	Senate Amendment
(c) Study to Develop a Strategy for Quality Review and Assurance.— *(1) In General.*—Requires the Secretary to arrange for a study to serve as the basis for establishing a strategy for reviewing and assuring the quality of care under Medicare. *(2) Items Included in the Study.*—The study is required among other items, to (a) identify the appropriate considerations which should be used in defining "quality of care"; (b) evaluate the relative roles of structure, process, and outcome standards in assuring quality of care; (c) consider whether criteria and standards for defining and measuring quality of care should be developed and, if so, how this should be done; (d) evaluate the adequacy and focus of the current methods for measuring, reviewing, and assuring quality of care; (e) evaluate the current research on methodologies for measuring quality of care, and suggest areas of research needed for further progress; (f) evaluate the adequacy and range of methods available to correct or prevent identified problems with quality of care; (g) review mechanisms available for coordinating and supervising at the national level quality review and assurance activities; and (h) develop general criteria which may be used in establishing priorities in the allocation of funds and personnel in reviewing and assuring quality of care. *(3) Report.*—Requires the Secretary to report to Congress, no later than 2 years after the date of enactment. The report shall address the items in (2) above and shall include recommendations with respect to strengthening quality assurance and review activities for Medicare services. *(4) Arrangement for Study.*—Requires the Secretary to request the National Academy of Sciences, acting through appropriate units, to submit an application to conduct the study described in this subsection. If the Academy submits an acceptable application, the Secretary is required to enter into an appropriate arrangement with the Academy for conducting the study. If the Academy does not submit an acceptable application, the Secretary may request one or more appropriate nonprofit private entities to submit an application to conduct the study and may enter into an arrangement for the study with the entity which submits the best application.	*(c) Study to Develop a Strategy for Quality Review and Assurance.*—No provision.

II. MEDICARE PROVISIONS (PARTS A AND B)—Continued

Item	Present Law
12. Technical Amendments and Miscellaneous Provisions Relating to Parts A and B (Sections 10224, 4504, and 4509 of House bill)	*(a) Treatment of Group Purchasing Vendor Agreements.*—It is prohibited to receive, give, solicit, or offer any remuneration in return for referring or arranging for the furnishing of any item or service or in return for purchasing, leasing, or ordering any good, facility, or service for which payment can be made under Medicare. Some hospitals and other providers purchase medical supplies and equipment through their participation in group purchasing organizations (GPOs). GPOs purchase goods and services for participating institutions. A service or transactional fee is charged to participating institutions by GPOs. In some situations, fees are also paid by the vendor or supplier in order to participate in the GPO agreement. This practice constitutes a technical violation of Medicare anti-fraud and abuse preventions. *(b) Extension and Clarification of Competitive Contracting Authority.*—DEFRA provided the Secretary with the authority to enter into two competitively bid contracts under part A and two such contracts under part B to replace poor performing contractors, i.e., intermediaries and carriers. This authority expires on September 30, 1986. While the Secretary has used this authority to enter into competitively bid cost contracts, competitive bidding has not been used in the negotiation of fixed-price contracts.

House Bill	Senate Amendment
Requires the Secretary, in developing plans for the conduct of the study, to assure that consumer and provider groups, peer review organizations, the Joint Commission on Accreditation of Hospitals, professional societies, and private purchasers of care with experience and expertise in the monitoring and quality of care are consulted. ***Effective Date.***—Enactment.	
Outlay effect (in millions): Fiscal years: 1987 ..... 6 1988 ..... 8 1989 ..... 8 3-year total 22	***Outlay effect*** (in millions): Fiscal years: 1987 ..... 4 1988 ..... 7 1989 ..... 7 3-year total 18
(a) Treatment of Group Purchasing Vendor Agreements.— ***Section 10224.***—Permits the payment of administrative fees to group purchasing organizations by a vendor if the purchasing agent has an appropriate written contract and full disclosure of the payment is made to each provider. ***Section 4504.***—Similar provision. ***Section 4509.***—No provision.	No provision.
(b) Extension and Clarification of Competitive Contracting Authority.— ***Section 10224.***—Extends the authority of the Secretary for 3 years to enter into competitively bid contracts with intermediaries and contractors to replace poor performing contracts. Language would be clarified to include fixed-price contacting. ***Section 4504.***—No provision. ***Section 4509.***—No provision.	

II. MEDICARE PROVISIONS (PARTS A AND B)—Continued

Item	Present Law
	(c) Parts A and B COBRA Technical Corrections.—Current law contains a number of technical errors.
	(d) Delay in Promulgation of Regulations.—The Secretary may at any time issue regulations, instructions to Medicare carriers and fiscal intermediaries, and other instruments which change Medicare policy. Regulations must be issued in final form prior to August 15 or prior to October 6 to be included in the August or October Gramm-Rudman-Hollings baseline. As an exception to this general rule, proposed regulations updating prospective payments for hospital operating costs are included in the August or October Gramm-Rudman-Hollings baseline if they are issued prior to the August 15 or October 6 deadline.

House Bill	Senate Amendment
(c) Parts A and B COBRA Technical Corrections.— *Section 10224.*—Corrects technical errors as follows: (1) clarifies that a 1-year transition period is provided for foreign medical graduates (FMGs) who have not passed the Foreign Medical Graudate Examination in the Medical Sciences from July 1, 1986, through June 30, 1987, such a FMG will be counted at a rate equal to one-half of the rate at which the individual would otherwise be counted; (2) allows the Secretary to announce rather than publish health maintenance organization and competitive medical plan rates by September 7 of each year; (3) clarifies effective date of the provision regarding penalties for billing for assistants at surgery for certain cataract operations; (4) allows temporary use of carrier prepayment screening as a substitute for preprocedure review; (5) clarifies that the termination date of the ACCESS demonstration project is July 31, 1987; and (6) makes other miscellaneous corrections to COBRA and related laws.	
Section 4504.—No provision.	
Section 4509.—Identical provision.	
(d) Delay in Promulgation of Regulations.—The Secretary would be prohibited from issuing in final form any regulation, instruction, or other policy before September 15, 1987, which is estimated by the Secretary to achieve Medicare savings in fiscal year 1987 of more than $50,000,000, except as required to implement specific provisions required under statute. The Secretary would also be prohibited from publishing in final form any regulation regarding changes in the methodology for computing the amount of payment for capital-related costs for inpatient hospital services under Medicare part A between September 1, 1986 and September 1, 1987. References in current law to regulations issued in final or proposed form pursuant to Sections 1886(b)(3)(B), 1886(d)(3)(A), and 1886(e)(4) of the Social Security Act would be clarified. Under this provision, no such reference would be construed as including any regulation issued or proposed with respect to capital-related costs.	

II. MEDICARE PROVISIONS (PARTS A AND B)—Continued

Item	Present Law

House Bill	Senate Amendment
Effective date.—(a) Applies to payments made before, on, or after the date of enactment; (b) applies to contracts entered into on or after October 1, 1986; (c) applies as if it had been included in the enactment of COBRA; and (d) enactment.	

II. MEDICARE PROVISIONS (PARTS A AND B)—Continued

Item	Present Law
13. Direct Costs of Graduate Medical Education (Section 4501 of House bill)	COBRA restructured the manner in which Medicare reimburses teaching hospitals for the direct cost they incur for graduate medical education. Effective with cost reporting periods beginning on or after July 1, 1985, hospitals are to receive payment on the basis of a formula that takes into account each hospital's previous average cost per full-time equivalent resident, the number of full-time equivalent residents during the period for which reimbursement is being made, and the hospital's proportion of total inpatient days used by Medicare patients during that period. *(a) Clarifying Counting of Time Spent in Outpatient Settings.*—Time spent by residents out of the inpatient setting is counted for this purpose only if the setting is part of the hospital. *(b) Reducing Maximum Initial Residency Period.*—Beginning on July 1, 1986, distinctions are made among residents, for purposes of counting their full-time equivalency in this formula, and different weighting factors are applied depending on how many years of residency training they have completed. Residents are weighted at 1.00 during the period needed to obtain their first board eligibility, plus one additional year, not to exceed a total of 5 years. This results in full payments for either 4 or 5 years. After the initial residency period, payments are reduced; beginning on July 1, 1987, payments for such residents are reduced to half (i.e., a weighting factor of .50) of what they would otherwise have been.

House Bill	Senate Amendment
	No provision.

(a) Clarifying Counting of Time Spent in Outpatient Settings.—Counts only time spent in patient care activities towards the determination of full-time equivalency (used in determining payments for direct graduate medical education costs), and counts all time so spent by a resident under an approved medical residency training program, without regard to the setting in which the activities are performed, if the hospital incurs costs for the training program in that setting.

(b) Reducing Maximum Initial Residency Period.—Reduces the length of the initial residency period from 5 years to 4 years. As a result, the support for the fifth year of residency is reduced by half (i.e., a weighting factor of .50), conforming to policy adopted in COBRA for the sixth and succeeding years.

Provides a one year transition, from July 1, 1987, through June 30, 1988, during which support for the fifth year of residency is reduced by one-quarter (i.e., a weighting factor of .75 instead of .50) for a resident whose support would otherwise be reduced by half.

Effective date.—Applies to payments for approved residency training programs as of July 1, 1987.

Outlay effect (in millions):

Fiscal years:	
1987	0
1988	0
1989	−6
3-year total	−6

Item	Present Law
14. Cost Limits for Home Health Agencies (Section 4502 of House bill; Section 613 of Senate amendment)	Section 1861(v)(1)(L) of the Social Security Act authorizes the Secretary to set limits on home health agency costs which may be recognized as reasonable in the efficent delivery of services. The Secretary is authorized to establish limits for home health agencies at the 75th percentile of the average cost per visit for freestanding home health agencies, or at a lower percentile or comparable or lower limit as the Secretary may determine. The Secretary is also authorized to provide for exemptions and exceptions to these limits as he deems appropriate. Prior to final regulations published by the Secretary on July 5, 1985, limits to home health agencies were established by regulation at the 75th percentile of the labor-related component of per visit cost and the nonlabor component of per visit cost. Separate limits were established for each type of service (e.g., skilled nursing, home health aide, physical therapy); however they were applied in the aggregate to each home health agency based on its mix of services. With the regulations published July 5, 1985, HCFA revised the home health limit methodology. For cost reporting periods beginning on or after July 1, 1985, the limits were set at 120 percent of the mean labor-related and nonlabor component of per visit costs. For cost reporting periods beginning on or after July 1, 1986, the limits are set at 115 percent of the mean, and for cost reporting periods beginning on or after July 1, 1987, the limits are to be set at 112 percent of the mean. These regulations also established and applied separate limits for each type of service.

House Bill	Senate Amendment
(a) Application of Cost Limits.—Amends the Secretary's authority to establish limits for home health agency costs to require that limits be applied on an aggregate basis for all home health services, rather than on a discipline-specific basis, with appropriate adjustment for administrative and general costs of hospital-based agencies. The Secretary is also required to base limits on the most recent data available, which may be for cost reporting periods beginning no earlier than October 1, 1983. The Secretary must also take into account the changes in costs of home health agencies for billing and verification procedures that result from the Secretary's changing the requirements for such procedures, to the extent these changes in costs are not reflected in available data.	*(a) Application of Cost Limits.*—Repeals the Secretary's authority to establish home health limits at the 75th percentile of the average per visit cost and replaces it with authority to establish, for the cost reporting periods beginning on or after July 1, 1985, limits at 120 percent of the mean of the labor-related and nonlabor component of per visit costs for freestanding home health agencies; for cost reporting periods beginning on or after July 1, 1986, limits at 115 percent of the mean; and for cost reporting periods beginning on or after July 1, 1987, limits at 112 percent of the mean. Requires that for cost reporting periods beginning on or after Oct. 1, 1986, limits must be applied on an aggregate basis, rather than on a discipline-specific basis, with appropriate adjustment for administrative and general costs of hospital-based agencies.
(b) GAO Study.—Requires the Comptroller General to study and report to Congress by April 1, 1987, on: (1) the appropriateness and impact on Medicare beneficiaries of applying per visit home health agency cost limits on a discipline-specific basis, rather than on an aggregate basis; and (2) the appropriateness of the percentage limits established in regulation.	*(b) GAO Study.*—Requires the Comptroller General to study and report to Congress, not later than Sept. 1, 1987, on the appropriateness of applying per visit home health agency cost limits on a discipline-specific basis, rather than on an aggregate basis.
Effective date.—Cost reporting periods beginning on or after July 1, 1985.	*Effective date.*—Enactment.

II. MEDICARE PROVISIONS (PARTS A AND B)—Continued

Item	Present Law

House Bill	Senate Amendment
Requirement for the Secretary to base limits on most recent data available: effective for cost reporting periods beginning on or after July 1, 1985.	
Requirement for the Secretary to take into account changes in costs for billing and verification procedures: effective for changes in requirements of Secretary effected before, on, or after July 1, 1985.	
Outlay effect (in millions):	*Outlay effect* (in millions):
Fiscal years:	Fiscal years:
1987 30	1987 15
1988 15	1988 15
1989 20	1989 20
3-year total 65	3-year total 50

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II. MEDICARE PROVISIONS (PARTS A AND B)—Continued

Item	Present Law
15. Establishment of Research Program (Section 4503 of House bill; Section 616 of Senate amendment)	No provision. A growing body of research on the utilization of medical services indicates variations in the scope of care furnished to otherwise comparable populations. Such research raises questions that have a bearing on policy decisions affecting the Medicare program. These include questions about the quality of care, the appropriateness of care, and the cost-effectiveness of care being received by Medicare enrollees and the effects of the payment methodologies and quality assurance measures currently employed.

House Bill	Senate Amendment
(a) Research Projects.—Requires the Secretary to provide for a research program on patient outcomes of selected medical treatments and surgical procedures for the purpose of assessing their appropriateness, necessity, and effectiveness. The research is required to include (1) assessments of the extent of uncertainty regarding appropriateness; (2) assessments of the appropriateness of admissions or selection criteria; (3) development of improved measures of patient outcome; (4) evaluation of patient outcome; and (5) efforts to reduce existing levels of uncertainty or disagreement regarding appropriateness.	*(a) Research Project.*—Similar provision, except the research is required to include (1) reorganization of data relating to claims under Part A and B in a manner that facilitates research with respect to patient outcomes; (2) assessments of the appropriateness of admissions and discharges; (3) assessments of the extent of professional uncertainty regarding efficacy; (4) development of improved methods for measuring quality-of-life patient outcomes; (5) model evaluations of patients outcomes, and (6) evaluation of the effects on physicians' practice patterns of the dissemination to physicians and peer review organizations of the findings of the research in items (2), (3), (4), and (5) above.
(b) Study Priorities.—Requires the Secretary, in selecting treatments and procedures to be studied, to give priority to those medical and surgical treatments and procedures (1) for which data indicate a highly (or potentially highly) variable pattern of utilization among Medicare beneficiaries in different geographic areas; and (2) which are significant (or potentially significant) for purposes of this title in terms of utilization by beneficiaries, length of hospitilization associated with the treatment or procedure, costs to the program and risk involved to the beneficiary.	*(b) Study Priorities.*—Identical provision.
(c) Funding Levels.—Makes available, for the purposes of carrying out the research program, (1) from the Federal Hospital Insurance Trust Fund—$4 million for FY 1987, $5 million for FY 1988, and $5 million for FY 1989; and (2) from the Supplementary Medical Insurance Trust Fund—$2 million for FY 1987, $2.5 million for 1988, and $2.5 million for FY 1989.	*(c) Funding Levels.*—Makes available, for the purposes of carrying out the research program, (1) from the Federal Hospital Insurance Trust Fund—$3 million for FY 1987, $2.75 million for FY 1988, and $1.75 million for FY 1989; and (2) from the Supplementary Medical Insurance Trust Fund—$3 million for FY 1987, $2.75 million for FY 1988; and $1.75 million for FY 1989.
(d) Funding Distribution—Requires not less than 90 percent of each fiscal year's appropriation to be used to fund grants to and cooperative arrangements with, non-Federal research entities. The remaining funds may be used by the Secretary for research by Federal entities and for administrative costs.	*(d) Funding Distribution.*—Identical provision.

II. MEDICARE PROVISIONS (PARTS A AND B)—Continued

Item	Present Law

House Bill	Senate Amendment
(e) Administration.—Requires the research program to be run by the National Center for Health Services Research and Health Care Technology. The Center is required to establish application procedures for grants and cooperative agreements. The Center is required to establish peer review panels to review all such applications and all research findings. The Center is required to consult with the Council on Health Care Technology in establishing the scope and priorities for the research program and shall report periodically to the Council on the status of the program.	***(e) Administration.***—Similar provision.
(f) HHS Cooperation.—Requires the Secretary to make available data derived from the Medicare program and any other HHS programs for use in the research program.	***(f) HHS Cooperation.***—Identical provision.
(g) Report to Congress.—Requires the Center to report to the Senate Committees on Finance and Appropriations and the House Committees on Ways and Means, Energy and Commerce, and Appropriations no later than 18 months after enactment, and annually thereafter, on the research program's findings.	***(g) Report to Congress.***—Identical provision.
(h) Dissemination of Findings.—Requires the Center, in cooperation with appropriate medical specialty groups, to dissiminate the research program's findings as widely as possible, including disseminating the findings to each peer review organization.	***(h) Dissemination of Findings.***—Identical provision.
(i) Permitting Services to be Provided Under Research Program.—Permits exceptions to the "reasonable and necessary" coverage exclusion , as necessary to carry out this research.	***(i) Permitting Services to be Provided Under Research Program.***—Identical provision.
Effective date.—October 1, 1986.	***Effective date.***—October 1, 1986.
Outlay effect (in millions):	***Outlay effect*** (in millions):
Fiscal years: 1987 ..... 6 1988 ..... 7 1989 ..... 8 3-year total 21	Fiscal years: 1987 ..... 5 1988 ..... 7 1989 ..... 8 3-year total 20

II. MEDICARE PROVISIONS (PARTS A AND B)—Continued

Item	Present Law
16. Civil Monetary Penalty and Exclusion Provisions (Section 4505 of House bill)	Practitioners and institutions who present false or certain other improper claims or requests for reimbursement under the Medicare, Medicaid, or Maternal and Child Health Services Block Grant programs are, in addition to potential criminal penalties, subject to civil monetary penalties of up to $2,000 for each item or service and, in lieu of damages, an assessment of up to twice the amount claimed. Civil money penalty proceedings are prosecuted by the Inspector General of the Department of Health and Human Services before an administrative law judge; provider's may appeal adverse determinations to the appropriate U.S. Circuit Court of Appeals. In addition, individuals who have been convicted of criminal offenses related to their participation in Medicare and Medicaid are subject to exclusion from both programs; these individuals are entitled to an administrative hearing and, if the agency upholds the Inspector General's decision to exclude, judicial review.

House Bill	Senate Amendment
(a) Collateral Estoppel Effect of Prior Federal Criminal Convictions.—In a proceeding to bar a physician or other individual from participating in Medicare or Medicaid which is against an individual who has been convicted (whether upon a verdict after trial or upon a plea of guilty or nolo contendere) of a Federal crime charging fraud or false statements, and which involves the same transaction as in the criminal action, the individual cannot relitigate (i.e., is estopped from denying) the essential elements of the criminal offense in a subsequent civil case including a civil monetary penalties case.	No provision.
(b) Authority of Hearing Officer to Sanction Misconduct.—The official conducting such a hearing may sanction a person, including any party or attorney, for failing to comply with an order or procedure, failing to defend an action, or other mis-conduct that would interfere with the speedy, orderly, or fair conduct of the hearing. Requires the sanction to reasonably relate to the severity and nature of the failure or misconduct. The sanction may include: (1) in the case of refusal to provide or permit discovery, drawing negative factual inferences or treating such refusal as an admission by deeming the matter, or certain facts, to be established; (2) prohibiting a party from introducing certain evidence or otherwise supporting a particular claim or defense; (3) striking pleadings, in whole or in part; (4) staying the proceedings; (5) dismissal of the action; (6) entering a default judgment; (7) ordering the party or attorney to pay attorney's fees and other costs caused by the failure or misconduct; and (8) refusing to consider any motion or other action which is so filed in a timely manner.	

II. MEDICARE PROVISIONS (PARTS A AND B)—Continued

Item	Present Law

House Bill	Senate Amendment
(c) Clarification of Exclusion Authority for Certain Offenders.—Considers a physician or other individual to have been "convicted" of a criminal offense: (1) when a judgment of conviction has been entered against the physician or individual by a Federal, State, or local court, regardless of whether there is an appeal pending or whether the judgment of conviction or other record relating to criminal conduct has been expunged; (2) when there has been a finding of guilt against the physician or individual by a Federal, State, or local court; (3) when a plea of guilty or nolo contendere by the physician or individual has been accepted by a Federal, State, or local court; and (4) when the physician or individual has entered into participation in a first offender or other program when judgment of conviction has been withheld.	
Effective date.—(a) Applies on enactment, without regard to when a criminal conviction was obtained; (b) applies to failures or misconduct occurring on or after the date or enactment; and (c) applies to judgments entered, findings made, and pleas entered before, on or after the date of enactment (except for (4) which applies to participation in a program entered into on or after the date of enactment).	
Outlay effect.—None.	

II. MEDICARE PROVISIONS (PARTS A AND B)—Continued

Item	Present Law
17. Hospital Protocols for Organ Procurement and Standards for Organ Procurement Agencies (Section 4508 of House bill)	Current law does not include requirements with regard to hospitals and organ procurement protocols, or with respect to certification standards for organ procurement agencies. The Task Force on Organ Transplantation, created by the National Organ Transplant Act (P.L. 98-507), found that opportunities for obtaining organs were lost due to shortcomings in the present organ procurement process. The Task Force recommended legislation requiring that hospitals establish protocols for encouraging organ and tissue donation and requiring certification standards for organ procurement agencies.

House Bill	Senate Amendment
(a) Hospital Protocols.—Requires that the Secretary provide that no hospital may participate in Medicare or Medicaid unless the hospital has established protocols for encouraging organ and tissue donation. *(b) Criteria and Certification of Organ Procurement Agencies.*—Would prohibit payment under Medicare or Medicaid with respect to costs of procuring organs, by an organ procurement organization that is not qualified under section 317 (b) of the Public Health Service Act (or does not meet the standards to be qualified), and that has not been certified (and recertified at least every 2 years) as meeting the standards established by the Association of Independent Organ Procurement Agencies. *Effective date.*—Applies to hospitals as of July 1, 1987, and to the costs of organs procured on or after January 1, 1988. *Outlay effect.*—None.	No provision.

Item	Present Law
18. Medicare as Secondary Payer; Coverage Requirements for Certain Other Payers (Section 611 of Senate amendment)	TEFRA required employers to offer their employees ages 65 through 69 the same group health plans offered to employees under age 65. When the employee age 65 to 69 elects such coverage, Medicare becomes the secondary payer. The beneficiary retains the right not to elect such coverage and to be covered only by Medicare. DEFRA extended this provision to include beneficiaries covered under a working spouse's employer-based group health insurance plan when the working spouse is under age 65. COBRA further extended the provision to apply to the working aged and spouses over age 69.

House Bill	Senate Amendment
No provision.	Recodifies current law with respect to secondary payer provisions and amends the Social Security Act to provide that Medicare would be the secondary payer for all Medicare beneficiaries (including disabled and those who buy into Medicare) who elect to be covered by employment based health insurance as a current employee (or family member of such employee) of a large employer. This provision would explicitly include under the secondary payer provision those persons with group health coverage who are the employer, former employees under age 65, individuals associated with the employer in a business relationship, or members of the families of any such persons. Uniform rules are established as to the benefits Medicare pays when other payers are primary but do not pay the full charge. Payments under workers compensation or liability or related insurance are counted toward the Medicare deductible, as provided under current law for other types of primary payers. The secondary payer provisions are enforceable through private action or action brought by the Federal Government (with double damages payable). In addition, a tax is imposed on employers and employee organizations that contribute to plans that do not conform with the secondary payer provisions. The tax is 25 percent of the employer's or employee organization's annual contributions to nonconforming group health plans. Federal Medicaid payments to a State would be reduced by an amount equal to 25 percent of the group health plan expenses of a State that does not comply with the secondary payer provision. Conforming amendments are made to the section relating to special enrollment periods and premium penalties for part B of Medicare for individuals covered under employer based group health plans.

II. MEDICARE PROVISIONS (PARTS A AND B)—Continued

Item	Present Law

House Bill	Senate Amendment
	Effective date.—The special enrollment period and premium penalty provisions apply to enrollments occurring on or after October 1, 1986, and premiums for months beginning on or after October 1, 1986. All other provisions apply to items and services furnished in calendar quarters beginning on or after October 1, 1986. ***Outlay effect*** (in millions): Fiscal years: 1987 ..... −255 1988 ..... −340 1989 ..... −370 3-year total ..... −965

II. MEDICARE PROVISIONS (PARTS A AND B)—Continued

Item	Present Law
19. Coverage of Services of Nurse Anesthetists (Sections 4524 and 10207(a) of House bill)	Payments for services of certified registered nurse anesthetists (CRNAs) employed by hospitals are made to the hospital on a reasonable cost basis and are temporarily excluded from the definition of operating costs under PPS. For services of CRNAs employed by anesthesiologists, the anesthesiologist is paid on a reasonable charge basis as if he had performed the service. Physicians who provide medical direction for CRNAs employed by a hospital receive an adjusted reasonable charge payment. Provisions relating to payment for services of hospital-employed and physician-employed CRNAs are both effective for cost reporting periods beginning on or after October 1, 1984, and before October 1, 1987.

House Bill	Senate Amendment
(a) Payment Extension.— ***Section 10207(a).***—Extends current payment provisions for the services of CRNAs hospital-employed for cost-reporting periods beginning before October 1, 1988. [Note: See item 23(c) for related provision requiring study of prospective payment for radiology, anesthesia, and pathology services.] ***Section 4524.***—No provision. *(b) Direct Reimbursement for Services of a Registered Nurse Anesthetist.—* ***Section 10207(a).***—No provision. ***Section 4524.***—Authorizes direct reimbursement for anesthesia services and related care furnished by a registered nurse anesthetist which he/she is legally authorized to perform in the State. The term registered nurse anesthetist is defined as a registered nurse licensed by the State who meets such education, training, and other requirements relating to anesthesia services and related care as the Secretary may prescribe. The Secretary may use the same requirements as those established by a national organization for the certification of nurse anesthetists. Specifies that nothing in this section shall contravene provisions of State law relating to the practice of medicine or nursing or State law requirements or institutional requirements regarding the administration of anesthesia and its medical direction or supervision. Authorizes direct reimbursement for services equal to 80 percent of the reasonable charge for such services. The reasonable charge is the amount determined by the Secretary to be consistent with efficient and high quality anesthesia services taking into account the prevailing rate for such services. However, the reasonable charge must be adjusted to the extent necessary to ensure that the total amount paid for such services by Medicare in any fiscal year may not exceed the total amount which would have been paid if such services were included as inpatient hospital services and paid for under Part A, in the same manner as payment was made in	No provision.

II. MEDICARE PROVISIONS (PARTS A AND B)—Continued

Item	Present Law

House Bill	Senate Amendment
fiscal year 1986, adjusted to take into account changes in prices and technology relating to the administration of anesthesia. Requires the Secretary to adjust the reasonable charge for medical direction of services of registered nurse anesthetists to the extent necessary to ensure that the total amount paid for medical direction and services would not exceed the amount which would have been paid in the absence of this provision. If the adjustment results in a reduction in the reasonable charge for a non-participating physician, such physician may not charge more than 125 percent of the adjusted prevailing charge; if the physician charges more, the physician would be required to refund the excess to the individual. If the physician knowingly and willfully imposes charges or fails to make required refunds, the Secretary could impose sanctions. ***Effective date.***—Section 10207(a).—Enactment. Section 4524.—Applies to items and services furnished on or after October 1, 1987. ***Effective date.—*** ***Section 10207(a).***—Enactment. ***Section 4524.***—Applies to items and services furnished on or after October 1, 1987. ***Outlay effect:*** ***Section 10207(a).***—None. ***Section 4524.***—None.	

II. MEDICARE PROVISIONS (PART B)

Item	Present Law
20. Extension of Premium Payment Provision Through 1989 (Section 10231 of House bill; Section 1001(c) of Senate amendment)	Under the original Medicare law, beneficiary premiums paid for 50 percent of the program cost of part B with the remaining 50 percent financed by Federal general revenues. However, between 1974 and 1982 the law limited the percentage increase in the part B premium to the percentage increase in Social Security cash benefits payments. By 1982, beneficiary premiums paid for approximately 25 percent of program costs. TEFRA, as amended by the Social Security Amendments of 1983 (P.L. 98-21), specified that enrollee premiums in 1984 and 1985 would be allowed to increase to amounts necessary to produce premium income equal to 25 percent of program costs for elderly enrollees. If there is no Social Security COLA, the monthly premium would not be increased in that year. If the amount of a premium increase is greater than the Social Security COLA, the premium increase is to be reduced so as to avoid a reduction in the individual's Social Security check. Disabled enrollees pay the same premiums, though the per capita cost of services to these enrollees is higher. DEFRA extended this provision for 1986 and 1987, COBRA extended this provision through 1988. Beginning January 1, 1989, the premium calculation reverts to the earlier method.

House Bill	Senate Amendment
(a) One Year Extension.—Extends the current 25 percent payment provision for one additional year, through calendar year 1989.	*(a) One Year Extension.*—No provision.
(b) Technical Conforming Change.—No provision.	*(b) Technical Conforming Change.*—Makes technical clarifying changes in provision reducing the premium increase where necessary to avoid a reduction in the individual's Social Security checks.
	Effective date.—Applies with respect to monthly premiums for months after December 1986.
	Outlay effect.—None.
Effective date.—Enactment	
Outlay effect (in millions):	
Fiscal years:	
1987 0	
1988 0	
1989 ..... −380	
3-year total ..... −380	

Item	Present Law
21. Payments for Physicians' Services (Sections 10232 (a–d, and f–j) and Section 4525 of House bill; Sections 621(b–c) and 622 of Senate amendment)	Payments are made to physicians on the basis of reasonable charges. The reasonable charge for a service is the lowest of the actual charge, the physician's customary charge for the service or the prevailing charge for the service in the community. The prevailing charge for a service is the lower of the 75th percentile of customary charges for the service in the area, or the maximum allowed prevailing charge, which is the unadjusted prevailing charge in a base year increased by the Medicare economic index (MEI). DEFRA froze physician fees for the 15-month period July 1, 1984 through September 30, 1985. P.L. 99–107, as amended, and COBRA extended this freeze through April 30, 1986 for participating physicians and December 31, 1986 for nonparticipating physicians. Since July 1, 1984, the actual charges of nonparticipating physicians have been subject to a freeze. Violations have been subject to sanctions. The freeze expires on December 31, 1986. On May 1, 1986, participating physicians received an increase in prevailing charges based on the MEI for 1986 plus an additional one percentage point. The one percentage point increase is temporary and will not be included after December 31, 1986. Participating and nonparticipating physicians will receive a prevailing charge increase each year beginning on January 1987. The increase for non-participating physicians is to be lagged and will be based on the MEI for the preceding year. The MEI, expressed as a maximum allowable percentage increase, has been tied to economic indexes reflecting changes in physician operating expenses and earnings levels. On August 12, 1986, the Administration has by regulation revised the calculation of the MEI to account for an adjustment to the housing cost component, which the Administration believes to be historically overstated. The index would be computed retroactively using the rental equivalence housing component of the CPI as a substitute for the home ownership approach. COBRA required the Secretary, with the advice of the newly established Physician Payment Review Commission, to develop a relative

House Bill	Senate Amendment
(a) Maximum Allowable Prevailing Charges.— *Section 10232.*—On January 1, 1987, all physicians will receive an increase in prevailing charges based on the percentage increase in the Medicare economic index (MEI) for services provided in 1987. The increase will apply to the maximum allowable prevailing charges of participating and nonparticipating physicians respectively in effect during the 8-month period ending on December 31, 1986. The Secretary is required to treat the maximum allowed prevailing charges recognized for participating and nonparticipating physicians respectively during such 8-month period as having been justified by economic changes. In years subsequent to 1987, the maximum allowed prevailing charges of participating and nonparticipating physicians is to be increased by the MEI increase factor applicable for services provided during the year. *Section 4525.*—Specifies that the one percentage point increase for participating physicians permitted on May 1, 1986 is built into the MEI base for future calculations. Allows an MEI update for all participating physicians and all assigned claims submitted by nonparticipating physicians. Limits increases in prevailing charges for unassigned claims to 1 percent in 1987.	*(a) Maximum Allowable Prevailing Charges.—* No provision.
(b) Bonus for Participating Physicians.— *Section 10232.*—Provides that in applying the percentage increase in the MEI for physicians' services furnished by participating physicians during each year after 1986, the Secretary shall provide for a bonus of one percentage point in the percentage increase otherwise determined. Such a bonus for each year will apply to physicians' services furnished only during the year and not in the calculation of payments for any subsequent year. *Section 4525.*—No provision.	*(b) Bonus for Participating Physicians.*—No provision.
(c) Limit on Actual Charges for Nonparticipating Physicians.— *Section 10232.*—The current freeze on actual charges of non-participating physicians would	*(c) Limit on Actual Charges for Nonparticipating Physicians.*—No provision.

Item	Present Law
	value scale for physician payments. The Secretary is required to complete the development of the RVS and report to Congress on its development by July 1, 1987. The report is to include recommendations concerning its potential application to Medicare on or after January 1, 1988.

House Bill	Senate Amendment
be replaced by a role of increase limit. In 1987, nonparticipating physicians could increase their actual charges above levels in effect during the calendar quarter beginning April 1, 1984 by an amount equal to the MEI for 1987 plus one percentage point. For nonparticipating physicians without actual charges for a procedure during the calendar quarter beginning April 1, 1984, the limit is the 50th percentile of customary charges (weighted by frequency of the procedure) for the procedure performed by nonparticipating physicians in the locality during the 12-month period ending June 30, 1986 increased by the MEI for 1987 plus one percentage point. In future years, the limit is the maximum allowed charge permitted for the previous year increased by the percentage increase in the MEI. If the physician knowingly and willfully bills for actual charges in excess of permitted charges, the Secretary may apply sanctions for noncompliance. Carriers are required to provide available information to nonparticipating physicians to enable them to determine maximum allowed charges. In calculating customary charges for services furnished on or after January 1, 1988, the Secretary shall not recognize any increases in actual charges in excess of these limits. ***Section 4525.***—Similar provision with respect to monitoring of charges and application of sanctions. Nonparticipating physicians could increase their actual charges in 1987 by the percentage increase in the MEI for assigned claims and only by 1 percent for nonassigned claims. In calculating customary charges for services furnished during 1988 and 1989, the Secretary shall not recognize any increase in actual charges in excess of the limits.	
(d) Medicare Economic Index (MEI).— ***Section 10232.***—Prohibits the Secretary from revising the MEI in a manner that provides for any period before January 1, 1985, for the substitution of a rental equivalence or rental substitution factor for the housing component of the consumer price index. ***Section 4525.***—Identical provision.	***(d) Medicare Economic Index (MEI).***—Provides that the adjustment of the MEI as proposed by the Administration would be made in two stages, with one-half of the adjustment becoming effective January 1, 1987, and the other half January 1, 1988. The Secretary is required to utilize the rule-making process for proposed changes in the methodology, basis, or elements of the MEI.

II. MEDICARE PROVISIONS (PART B)—Continued

Item	Present Law

House Bill	Senate Amendment
(e) Reasonable Charge Limitations.—(See item 21, Inherent Reasonableness.)	***(e) Reasonable Charge Limitations.***—(See item 21, Inherent Reasonableness.)
(f) Recruiting.—	***(f) Recruiting.***—No provision.
Section 10232.—Requires carriers to implement programs to recruit and retain physicians as participating physicians, including educational and outreach activities and the use of professional relations personnel to handle billing problems for participating physicians. Carriers are also required to implement programs to familiarize beneficiaries with the participating physician program and to assist them in locating participating physicians. The Secretary is required to provide a system for measuring carriers' performance with respect to these responsibilities or those specified under section 1842(h) of the Social Security Act. An incentive pool, equal to 1 percent of total payments to carriers for claims processing, will be available to reward carriers for their success in increasing the percentage of participating physicians in the carrier's service area.	
Section 4525.—No provision.	
(g) Directories of Participating Physicians.—	***(g) Directories of Participating Physicians.***—No provision.
Section 10232.—Requires the Secretary to provide that each appropriate area directory is sent to each Part B beneficiary residing in the area and that an appropriate number of copies is sent to hospitals in the area. The copies are to be sent free of charge. Requires each directory to provide alphabetical listings for: (1) all participating physicians in the area; and (2) locality and specialty of such physicians.	
Section 4525.—No provision.	

II. MEDICARE PROVISIONS (PART B)—Continued

Item	Present Law

House Bill	Senate Amendment
(h) Prohibiting Unassigned Billing of Services Determined to be Medically Unnecessary by a Carrier.—	*(h) Prohibiting Unassigned Billing of Services Determined to be Medically Unnecessary by a Carrier.*—No provision.
Section 10232.—Provides that, where a physician has provided services on a nonassigned basis which are determined by a peer review organization or carrier to be unnecessary, the physician is required to refund any amounts collected from the beneficiary within 30 days after receiving a notice that the services were unnecessary or within 15 days after receiving notice of an adverse determination upon reconsideration or appeal. A refund would not be required if: (i) the physician did not know and could not reasonably have been expected to have known that the services would be found to be unnecessary; or (ii) the beneficiary was informed in advance that Medicare payment would not be made for a specific service and agreed to pay for the service. Physicians who knowingly and willfully fail to make required refunds on a timely basis would be subject to civil money penalties and/or exclusion from the Medicare program. Carriers and peer review organizations would be required to send denial notices based on medical necessity determinations to the physician and the beneficiary.	
Section 4525.—No provision.	
(i) Maintenance and Use of Participating Directories by Hospitals.—	*(i) Maintenance and Use of Participating Directories by Hospitals.*—No provision.
Section 10232.—Amends Medicare participation agreements to require hospitals to make available directories of participating physicians and, where referral is made to a nonparticipating physician, inform the beneficiary of such fact. Wherever practicable, the hospital must identify at least one qualified participating physician.	
Section 4525.—No provision.	

II. MEDICARE PROVISIONS (PART B)—Continued

Item	Present Law

House Bill	Senate Amendment
(j) Submission and Disclosure of Information on Unassigned Claims.—	*(j) Submission and Disclosure of Information on Unassigned Claims.*—No provision.
Section 10232.—Provides that where the actual charge on an unassigned elective surgical procedure exceeds $500, the physician is required to disclose to the individual in writing, the estimated charge, the estimated approved charge, and the excess of the physician's actual charge over the approved charge. A physician failing to comply with this requirement would be required to refund payments received in excess of the Medicare approved charge. Knowing and willful failures to make required refunds would be subject to civil money penalties and/or exclusion from Medicare.	
Section 4525.—No provision.	
(k) HCFA Common Procedure Coding System.—No provision.	*(k) HCFA Common Procedure Coding System.*—Requires by July 1, 1987, the consolidation of the payment methodology under HCFA's Common Procedures Coding System (HCPCS) and mandates its use for hospital outpatient services by the same date. Carriers and intermediaries are required to report services and claims using HCPCS by January 1, 1988.
(l) Recommendations for Relative Value Scale (RVS).—No provision.	*(l) Recommendations for Relative Value Scale (RVS).*—Requires the Secretary in making recommendations for application of an RVS to: 1) develop and assess an appropriate index to reflect justifiable geographic variations in practice costs without exacerbating the geographic maldistribution of physicians; and 2) assess the advisability and feasibility of developing an appropriate adjustment to assist in attracting and retaining physicians in medically underserved areas. The Secretary is to take into account recommendations of the Physician Payment Review Commission. The Secretary is to develop an interim geographic index by July 1, 1987, and collect data for refining the index by December 31, 1989. The date the Secretary is required to report on the RVS is deferred to July 1, 1989. The potential application date of the RVS is deferred until after December 31, 1989.

II. MEDICARE PROVISIONS (PART B)—Continued

Item	Present Law

House Bill	Senate Amendment
Effective date.—*Section 10232:* (a) and (c) apply to services furnished on or after January 1, 1987. (b) and (d) are effective on enactment. (f) applies to carrier contracts as of October 1, 1987; carrier bonus payments shall be first paid not later than April 1, 1988, to reflect performance of carriers during November 1987. (g) applies for distribution of directories to beneficiaries for 1988 directories; organization of directories applies to 1987 directories. (h) applies to services furnished on or after October 1, 1987. (i) applies to agreements as of October 1, 1987. (j) applies to surgical procedures performed on or after October 1, 1987. *Section 4525:* (a) and (c) applies to services furnished on or after January 1, 1987. (d) effective on enactment.	***Effective date.***—Enactment.
Outlay effect (in millions):	***Outlay effect*** (in millions):
Section 10232: Fiscal years: 1987 ..... 55 1988 ..... 145 1989 ..... 50 3-year total 250	Fiscal year: 1987 ..... −50 1988 ..... −200 1989 ..... −250 3-year total ..... −500
Section 4525: Fiscal years: 1987 ..... 0 1988 ..... −70 1989 ..... −105 3-year total ..... −175	

Item	Present Law
22. Inherent Reasonableness; Payments for Cataract Surgery (Section 10232(e), Section 4526 and Section 4527 of House bill; Section 621(a) of Senate amendment)	***(a) Reasonable Charge Limits/Inherent Reasonableness.***—COBRA required the Secretary to promulgate regulations which specify explicitly the criteria of "inherent reasonableness" which are to be used for determining Medicare payments. On August 11, 1986, the Administration by regulation published "inherent reasonableness" guidelines. There is no authority under current law for the Secretary to limit the actual charges billed by a physician or supplier to protect the beneficiary against increased expenses when Medicare payments are reduced.

House Bill	Senate Amendment
(a) Reasonable Charge Limits/Inherent Reasonableness.—	*(a) Reasonable Charge Limits/Inherent Reasonableness.*
Section 10232.—	(i) No provision.
(i) Specifies that for nonphysicians' services, the inherent reasonableness limitation may be used only by carriers and only in calculating prevailing charges for an item or service by eliminating charges for specific items or services in specific instances in which the charges, in comparison with the charges for similar items and services, are grossly excessive or deficient.	
(ii) Prohibits the Secretary, through regulations, guidelines, instructions or otherwise, from requiring carriers to reduce payment amounts for specific items or services for which the Secretary had made a specific determination that the payment amounts or charges are excessive.	(ii) Specifies that the inherent reasonableness authority must be applied through regulation for physicians and prohibits carriers from acting independently, without the issuance of regulations.
(iii) Requires the Secretary, after consultation with the Physician Payment Review Commission, to submit to Congress by April 1, 1987, recommendations concerning payment reductions for overpriced items and services. The recommendations are to include the specific payment reductions recommended and measures to assure that reductions in payment do not result in corresponding increases in out-of-pocket costs to Medicare beneficiaries.	(iii) Requires the Secretary, by October 1, 1987 to review the inherent reasonableness of reasonable charges for each of the 10 most costly procedures paid for under part B, determined on the basis of aggregate annual payments. The Secretary may review additional procedures.
Section 4526.—	
(i) Requires the Secretary before exercising the authority to adjust reasonable charges, to make specific findings. Specifies that the Secretary may compare: charges and resource costs for related procedures; charges and resource costs for the procedure over a period of time; charges for procedures in different geographic areas; and charges and allowed payments by Medicare and other payers. An adjustment on the basis of a comparison of prevailing charges in different localities may only be made if the Secretary determines that the prevailing charge allowed in one locality is grossly out of line with	(i) Specifies the factors to consider in determining the inherent reasonableness of charges. The identified factors would include cases where: prevailing charges are significantly different from those in comparable localities; Medicare and Medicaid are the main sources of payment; the marketplace for the service is not truly competitive because of the limited number of physicians performing the service; there have been increases in charges not explained by inflation; charges do not reflect changing technology or reductions in acquisition or production costs, or the prevailing charges are substantially higher than payments made by other purchasers. Regional differences in fees are to be taken into account unless there is substantial economic justification for a uniform national fee or payment limit.

Item	Present Law
	(b) Payments for Cataract Surgery.—Payments for cataract surgery are made on the basis of reasonable charges. Payments for anesthesia services are based on a method that combines base units (with values assigned to each procedure) and time units. If the Secretary were to reduce Medicare payments for these services, under "inherent reasonableness," he would not have authority to limit the actual charge billed to the patient.

House Bill	Senate Amendment
prevailing charges allowed in other localities after accounting for differences in practice costs. Specifies that the Secretary, in determining whether to adjust payment rates, shall consider the following: potential impacts on quality, access, and beneficiary liability of the adjustment; likely effects on assignment rates, reasonable charge reductions on unassigned claims, and participation rates of physicians; proportion of such procedures for which payment is available under Medicare; and the prevailing charge of other third-party payers for the procedure.	
(ii) Specifies that the Secretary is required to consult with the Physician Payment Review Commission with respect to a proposed adjustment, and after such consultation, publish a notice of the proposed adjustment and allow for public comment. The final notice must explain the factors and data taken into consideration in making the adjustment and respond to any comments made by the Physician Payment Review Commission.	(ii) Similar provision. Specifies that the proposed notice must explain factors and data taken into consideration and evaluate the impact on the accessability of and beneficiary liability for the service. Provides that the Commission shall comment on the proposed rule during the public comment period.
(iii) Provides that if the adjustment results in a reduction in the reasonable charge for a nonparticipating physician, the physician may not charge the beneficiary more than 125 percent of the adjusted prevailing charge. Any excess amounts must be refunded. The Secretary may impose sanctions in the case of violations.	(iii) No provision.
(b) Payments for Cataract Surgery.—	***(b) Payments for Cataract Surgery.***—No provision.
Section 4527.—	
(i) Places a limit on prevailing charges for cataract surgery with intraocular lens implantation equal to 110% of the prevailing charge recognized for such surgery without the lens implant. In determining the reasonable charge for cataract surgery anesthesia, the Secretary may not recognize more than 4 base units (as used for purposes of determining anesthesia payments on the date of enactment).	

II. MEDICARE PROVISIONS (PART B)—Continued

Item	Present Law

House Bill	Senate Amendment
(ii) Specifies that non-participating physicians may not charge more than 125% of the adjusted prevailing charge for cataract surgery with lens implantation and cataract surgery anesthesia. If the physician charges more he/she shall refund any excess amounts. The Secretary may impose sanctions in the case of physicians who knowingly and willfully impose excess charges or fail to make refunds.	
Effective date.—(a) Effective on enactment. (b) Applies to services furnished on or after January 1, 1987.	***Effective date.***—Applies to final regulations promulgated after July 1, 1986; required review by Secretary effective on enactment.
Outlay effect (in millions): ***Section 10232.***—Not available.	***Outlay effect*** (in millions): Fiscal years: 1987 ..... −100 1988 ..... −105 1989 ..... −120 3-year total ..... −325
Section 4526.—None.	
Section 4527.— Fiscal years: 1987 ..... −150 1988 ..... −220 1989 ..... −245 3-year total ..... −615	

Item	Present Law
23. End Stage Renal Disease Program Amendments (Sections 10233, 4506, and 4507 of House bill, Section 623 of Senate amendment)	The End-Stage Renal Disease Program (ESRD) provides coverage for the cost of routine maintenance dialysis for persons with chronic kidney (renal) failure. *(a) Composite Rate for Dialysis Treatment.*—The Secretary shall provide by regulation for a method of reimbursing facilities for routine maintenance dialysis care. Such method provides for the prospective determination of rates based on a single composite weighted formula which takes into account the mix of patients receiving dialysis services at home or in a facility and which reflects the relative costs of providing dialysis services in such settings. The Secretary may provide for exceptions to the prospective payment rates as may be warranted, such as for sole facilities located in isolated rural areas. In regulations published on May 13, 1983 (effective August 1, 1983), the Secretary established a prospective reimbursement rate for dialysis facilities. The reimbursement rates are calculated on per-treatment base rates (adjusted for wage differences) of $122.91 for independent facilities and $126.76 for hospital-based facilities. On May 13, 1986, the Secretary published a proposed rule that would reduce the base rates to $113.47 for independent facilities and $117.89 for hospital-based facilities. *(b) Payment for Physician's Services.*—Physicians are reimbursed for services related to routine maintenance dialysis care on the basis of a monthly capitation fee that encourages the use of home dialysis. The regulations establishing the payment rates for physicians were based, in part, on the assertion that the physician could oversee the dialysis care of ten home patients in the same amount of time as seven facility patients, resulting in a facility to home physician treatment capability ratio of 1 to 1.4 in the determination of the composite rate. On March 19, 1986, the Secretary published a proposed rule, based on a GAO study, that would change the facility to home physician treatment capability ratio to 1 to 3.9. On July 2, 1986, this change was published as a final rule, effective August 1, 1986. This change will result in an estimated reduction of physicians' average monthly capitation payments for dialysis care from $187.88 to $173.07.

House Bill	Senate Amendment
(a) Composite Rate for Dialysis Treatment.—	*(a) Composite Rate for Dialysis Treatment.*—
Section 10233.—Permits the Secretary to adjust the composite rates to dialysis facilities, but only if the base rate for dialysis in an independent facility is not less than $117.50 per treatment and only if the base rate for hospital-based facilities is not less than $121.50 per treatment. An application for a payment exception for sole facilities located in isolated rural areas shall be deemed approved unless the Secretary disapproves it by not later than 45 working days after the request for the exception is filed.	Prohibits the Secretary from reducing the current prospective payment dialysis rates prior to October 1, 1986. The Secretary is required to reduce the prospective payment dialysis rates by $1 for services rendered on or after October 1, 1986 and before October 1, 1988, and is prohibited from further reducing the rates during this period.
Section 4506.—Similar provision except that it adds pediatric dialysis facilities as a basis for payment exception requests, and applies 45 day deadline to all exception requests.	
(b) Payment for Physicians' Services.—	*(b) Payment for Physicians' Services.*—Same provision as Section 10233 of the House bill.
Section 10233.—Requires the Secretary to implement the changes in physicians' monthly capitation payments for dialysis payments as published in the Federal Register on July 2, 1986.	
Section 4506.—Provides that the Secretary shall establish a home to facility physician treatment capability ratio such that the average monthly capitation payment to physicians (based on a weighted average by State ESRD population) would be reduced to $180.00. Such adjustment is to be made such that it would apply to services rendered on or after August 1, 1986.	

Item	Present Law
	(c) Study of Dialysis Payment Rates.—No provision.
	(d) Coverage of Immunosuppressive Drugs.—Medicare provides coverage for kidney and heart transplants, including organ procurement costs, hospitalization, surgical fees, and immunosuppressive drugs provided in the hospital or administered by a physician.
	(e) Reorganization of ESRD Network Areas.—The Secretary shall establish renal disease network areas and such network organizations (including a coordinating council and medical review boards) for the purpose of assuring the effective and efficient administration of the ESRD program. The Secretary has established 32 network areas. Under COBRA, the Secretary may consolidate the number of network areas to not less than 14. The Secretary is proposing through regulations to reduce the number of network areas to 14 and to modify the current functions of the networks.

House Bill	Senate Amendment
(c) Study of Dialysis Payment Rates.—	*(c) Study of Dialysis Payment Rates.*—The Comptroller General shall conduct a study of facility payment rates for dialysis services and report to Congress not later than September 30, 1987.
Sections 10233 and 4506.—The Secretary shall provide for a study to evaluate the effectiveness of reductions in payment rates for facility and physician dialysis services and report to Congress not later than January 1, 1988. The Secretary is required to request the National Academy of Sciences to submit an application to conduct the study. If the Academy does not submit an acceptable proposal, the Secretary may request other appropriate entities to submit applications to conduct the study.	
(d) Coverage of Immunosuppressive Drugs.—	*(d) Coverage of Immunosuppressive Drugs.*—No provision.
Section 10233.—No provision.	
Section 4506.—Provides that immunosuppressive drugs furnished to a transplant patient within 1 year of the transplant would be a covered service under part B of Medicare.	
(e) Reorganization of ESRD Network Areas.—	*(e) Reorganization of ESRD Network Areas.*—No provision.
Sections 10233 and 4507.—Requires the Secretary to establish not less than 17 ESRD network areas, and to designate a network administrative organization that includes a network council of dialysis and transplant facilities in the area, and a medical review board. The Secretary shall develop standards, criteria and procedures for evaluating whether to enter into, continue or terminate an agreement with the network administrative organization. The Secretary may terminate such agreements only after applying such standards and finding that the organization has failed to perform its prescribed responsibilities. In the case of a termination, the Secretary may select a successor organization on the basis of competitive bidding. The Secretary shall designate the network areas not later than January 1, 1987. In first designating the network administrative organizations for the areas so established, the Secretary shall designate the current network organizations (or voluntary combinations of such organizations) unless such organizations do not meet the standards established.	

Item	Present Law
	(f) Patient Representation on Councils and Medical Review Boards.—At least one patient representative shall serve as a member of each network coordinating council and executive committee.
	(g) Responsibilities of Network Organizations.—The network organizations are responsible for: encouraging use of appropriate treatment settings, developing criteria, standards and network goals with respect to quality and appropriateness of treatment, evaluating procedures by which facilities assess appropriateness of treatment, identifying facilities not cooperating in achieving network goals, and submitting to the Secretary by July 1 of each year an annual report.
	(h) Facility Cooperation with Networks.—The Secretary may terminate or withhold certification of facilities that consistently fail to cooperate with network plans and goals.
	(i) Maximum Use of Vocational Rehabilitation Services.—It is the intent of Congress that the maximum practical number of patients who are medically, socially, and psychologically suitable for home dialysis or transplantation should be so treated.

House Bill	Senate Amendment
(f) Patient Representation on Councils and Medical Review Boards.—	*(f) Patient Representation on Councils and Medical Review Board.*—No provision.
Sections 10233 and 4507.—Requires at least one patient representative on each network council and each medical review board.	
(g) Responsibilities of Network Organizations.—	*(g) Responsibilities of Network Organizations.*—No provision.
Sections 10233 and 4507.—Amends the responsibilities of the network organizations to include in addition to current law functions: encouraging participation of patients, providers, and facilities in vocational rehabilitation programs, setting standards and criteria for such participation, reporting to the Secretary on facilities and providers not providing appropriate care, implementing a patient grievance process, conducting onsite review of facilities and providers, collecting and analyzing data to report to the Secretary, and providing data to assure maintenance of the National ESRD Registry.	
(h) Facility Cooperation with Networks.—	*(h) Facility Cooperation with Network Organizations.*—No provision.
Sections 10233 and 40507.—Adds failure to follow the recommendations of the medical review board as a basis for the Secretary to terminate or withhold certification.	
(i) Maximum Use of Vocational Rehabilitation Services.—	*(i) Maximum Use of Vocational Rehabilitation Services.*—No provision.
Sections 10233 and 4507.—Amends current provision to include that the maximum number of patients who are suitable for vocational rehabilitation services be given access to such services and encouraged to return to gainful employment.	

II. MEDICARE PROVISIONS (PART B)—Continued

Item	Present Law
	(j) National End Stage Renal Disease Registry.—The Secretary shall submit to Congress an annual report on the ESRD program.
	(k) Funding of ESRD Network Organizations.—No provision.
	(l) Reuse of Dialysis Filters and Other Dialysis Supplies.—No provision.

House Bill	Senate Amendment
(j) National End Stage Renal Disease Registry.—	***(j) National End Stage Renal Disease Registry.***—No provision.
Section 10233.—Requires the Secretary to establish a national end stage renal disease registry using data from networks, transplant centers and other sources that will permit: preparation of the Annual Report to Congress, analysis of the economic impact and medical efficacy of alternative treatment modalities, evaluation of the allocation of resources for treatment and research and measurement of patient mortality and morbidity rates and other indices of quality of care over time. The Secretary shall provide for the appointment of a professional advisory group and will report to Congress on the progress made in establishing such registry not later than January 1, 1987, and establish the registry by January 1, 1988.	
Section 4507.—Similar provision.	
(k) Funding of ESRD Network Organizations.—	***(k) Funding of ESRD Network Organizations.***—No provision.
Section 10233.—Requires the Secretary to reduce the composite rates paid to facilities by $0.50 per treatment (adjusted for modalities of treatment other than hemodialysis) and to provide for payment of such amounts to the network organization for the area in which the treatment is rendered to provide for the administrative costs of the networks.	
Section 4507.—Similar provision.	
(l) Reuse of Dialysis Filters and Other Dialysis Supplies.—	***(l) Reuse of Dialysis Filters and Other Dialysis Supplies.***—No provision.
Sections 10233 and 4507.—Requires the Secretary to establish protocols on standards and conditions for the reuse of dialysis filters for those facilities and providers who voluntarily elect to reuse such filters. The Secretary shall study the appropriateness of establishing protocols for reuse of other dialysis supplies and, where appropriate, the Secretary may establish such protocols. The protocols established are to be incorporated into the requirements of participation for facilities. Failure to follow such protocols may result in denial of participation or denial of payment for services not in compliance with such protocols.	

II. MEDICARE PROVISIONS (PART B)—Continued

Item	Present Law

House Bill	Senate Amendment
The Secretary shall establish the protocol on filter reuse not later than January 1, 1988 and shall report to Congress on the need for other such protocols by January 1, 1988.	
Effective date.—Enactment except for the following:	***Effective date.***—Enactment.
(a) Payment provision applies to services rendered on or after October 1, 1986. Exception provision applies to exception applications filed on or after October 1, 1986.	
(b) August 1, 1986, for section 4516.	
(d) Applies to immunosuppressive drugs provided on or after October 1, 1986.	
(e), (f), (g) and (h) No later than January 1, 1987.	
(k) Applies to treatment furnished on or after January 1, 1987.	
Outlay effect (in millions):	***Outlay effect*** (in millions):
Section 10233.—	
Fiscal years: 1987 ..... 10 1988 ..... 10 1989 ..... 10 3-year total 30	Fiscal years: 1987 ..... 50 1988 ..... 50 1989 ..... 0 3-year total 100
Section 4506.—Not available.	
Section 4507.—None.	

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Item	Present Law
24. Technical Amendments and Miscellaneous Provisions Relating to Part B (Sections 10234 and 4531 of House bill)	*(a) Additional Members for Physician Payment Review Commission.*—The Physician Payment Review Commission established by COBRA consists of 11 commissioners. The Commission was established to provide recommendations concerning physician reimbursement under part B. Commission members are appointed by the Director of the Office of Technology Assessment. *(b) Effective Date on Voluntary Disenrollment from Medicare.*—A beneficiary's coverage period under part B can be terminated by filing a notice that he or she no longer wishes to participate or by nonpayment of premiums. When a beneficiary files a notice to disenroll from part B, the effective date of the termination is the close of the calendar quarter following the calendar quarter in which the notice is filed; a termination for nonpayment of premiums takes effect with the end of a grace period (not more than 90 days). *(c) Study on Prospective Payment of Radiology, Anesthesia, and Pathology Services to Hospital Inpatients.*—The Health Care Financing Administration conducts a variety of studies on reimbursement, coverage, eligibility, and management alternatives under Medicare.

House Bill	Senate Amendment
(a) Additional Members for Physician Payment Review Commission. *Section 10234*—Expands the membership of the Physician Payment Review Commission by 2 members to 13. The Director of the Congressional Office of Technology Assessment shall appoint the two additional members of the Commission no later than 60 days after the date of the enactment of this Act, for terms of 3 years, except that the Director may provide initially for such terms as will ensure that (on a continuing basis) the terms of no more than five members expire in any 1 year. *Section 5431.*—Similar provision	No provision.
(b) Effective Date on Voluntary Disenrollment from Medicare.— *Section 10234.*—Modifies the effective date of disenrollment from Medicare when a beneficiary files a notice to disenroll to the close of the calendar quarter in which the notice is filed. *Section 4531.*—No provision.	
(c) Study on Prospective Payment of Radiology, Anesthesia, and Pathology Services to Hospital Inpatients.— *Section 10234.*—Requires the Secretary to study and report to the House Ways and Means Committee by April 1, 1987, concerning the implementation of a part B prospective payment system for radiology, anesthesia, and pathology services furnished to hospital inpatients. The report is required to include data, from a representative sample, showing, for discharges classified within each diagnosis-related group, the distribution of total reasonable charges and costs for each inpatient discharge for such services.	

II. MEDICARE PROVISIONS (PART B)—Continued

Item	Present Law

House Bill	Senate Amendment
Section 4531.—No provision. *Effective date.*—(a) enactment; (b) applies to notices filed on or after October 1, 1986; (c) enactment. *Outlay effect.*—None.	

Item	Present Law
25. Vision Care (Section 4521 of House bill)	Medicare pays for eye examinations furnished by a physican to a patient with a complaint or symptom of eye disease or injury. Medicare excludes payment for eyeglasses and eye examinations for the purposes of prescribing, fitting, or changing eyeglasses (except for prosthetic lenses for aphakic patients; that is, those without the natural lens of the eye). Payment is also excluded for procedures performed to determine the refractive state of the eye. An optometrist who is legally authorized by the State to practice optometry is defined as a physician, but only with respect to services related to the treatment of aphakic patients.

House Bill	Senate Amendment
Allows payment under Medicare for vision care services performed by optometrists, if the services are among those already covered by Medicare when furnished by a physician and if the optometrist is authorized by State law to provide the services. ***Effective date.***—Services furnished on or after April 1, 1987. ***Outlay effect*** (in millions): Fiscal years: 1987 ..... 35 1988 ..... 60 1989 ..... 70 3-year total 165	No provision.

II. MEDICARE PROVISIONS (PART B)—Continued

Item	Present Law
26. Occupational Therapy Service (Section 4522 of House bill; Section 625 of Senate amendment)	Medically necessary occupational therapy services are covered under part A when provided as part of covered inpatient hospital services, skilled nursing facility services, home health services or hospice care. Part B coverage is limited to treatment in a hospital outpatient department, comprehensive outpatient rehabilitation facility, home health agency, or when provided incident to physicians' services.

House Bill	Senate Amendment
(a) Services Furnished in Skilled Nursing Facilities and Other Providers.—Extends part B coverage of occupational therapy services to services provided in skilled nursing facilities (when part A coverage has been exhausted), in a clinic, rehabilitation agency, or public health agency or by others under arrangements with such entities. Reimbursement is on the basis of reasonable costs subject to the provision that the reasonable costs of services furnished under arrangements cannot exceed the amount that would be paid on a salary related basis.	*(a) Services Furnished in Skilled Nursing Facilities and Other Providers.*—Identical provision.
(b) Services Furnished in Beneficiary's Home and Private Offices.—Extends part B coverage to occupational therapy services furnished by an independently practicing therapist in a therapist's office or a beneficiary's home. The independently practicing therapist would be required to meet licensing and other standards prescribed by the Secretary. Reimbursement is on the basis of 80 percent of reasonable charges, with no more than $500 in incurred expenses eligible for coverage in a calendar year. A physician must certify the need for such services and a treatment plan must be established by a physician or by the qualified occupational therapist.	*(b) Services Furnished in Beneficiary's Home and Private Offices.*—Identical provision.
Effective date.—Applies to expenses incurred for outpatient occupational therapy services furnished on or after April 1, 1987.	*Effective date.*—Applies to expenses incurred for outpatient occupational therapy services furnished on or after October 1, 1986.
Outlay effect (in millions):	*Outlay effect* (in millions):
Fiscal years: 1987 ..... 15 1988 ..... 15 1989 ..... 20 3-year total 50	Fiscal years: 1987 ..... 20 1988 ..... 20 1989 ..... 20 3-year total 60

II. MEDICARE PROVISIONS (PART B)—Continued

Item	Present Law
27. Coverage of Services of a Physician Assistant (Section 4523 of House bill)	Payments are made to a physician for services and supplies furnished incident to a physician's professional services. The services of nonphysicians are covered as incident to physicians' services and such services must be rendered under the physician's direct supervision.

House Bill	Senate Amendment
(a) Covered Services.—Authorizes coverage of the services of physicians' assistants furnished under the supervision of a physician in a hospital, skilled nursing facility, or as an assistant-at-surgery. The physician assistant must be legally authorized to perform such services in the State in which the services are performed. Services and supplies furnished incident to these services are covered if they would be covered when furnished incident to physicians' services. *(b) Payment for Services.*—The prevailing charge for a service furnished by a physician's assistant may not exceed 90% of the prevailing charge for the same service when furnished by a physician. Payment may only be made to the employer of the physician assistant when services are provided on the basis of assignment. *Effective date.*—Services furnished on or after January 1, 1987. *Outlay effect.*—None.	No provision.

Item	Present Law
28. Payment for Clinical Diagnostic Laboratory Tests (Section 4528 of House bill)	Payment for clinical laboratory services are made on the basis of two fee schedules. One fee schedule is established for laboratory tests performed either in a physician's office or by an independent laboratory (including a hospital laboratory furnishing services to persons who are not patients of the hospital). A second schedule is established for hospital laboratory services provided to a hospital's outpatients. For the period beginning July 1, 1984, the rates under both schedules were established on a regional, statewide, or carrier service area basis. The first fee schedule was set at 60 percent of the prevailing charge levels established for the fee screen year beginning July 1, 1984. The second fee schedule was set at 62 percent of the prevailing charge levels established for the fee screen year beginning July 1, 1984. The fee schedules are adjusted annually to reflect changes in the consumer price index for all urban consumers. Beginning July 1, 1986, the Secretary is required to establish payment ceilings for each test to be applied nationwide. Beginning January 1, 1988, the fee schedule for tests performed either in a physician's office or by an independent laboratory is to be established on a national basis. At the same time, payment for hospital laboratory services is slated to revert to cost-based reimbursement.

House Bill	Senate Amendment
(a) Treatment of Hospital Outpatient Laboratories.—Conforms fee schedule for hospital outpatient laboratories to that for independent laboratories by eliminating the 2 percent differential and by eliminating the January 1, 1988, sunset provision on the fee schedule for such laboratory services. ***(b) National Fee Schedule.***—Eliminates requirement for the national fee schedule. The Secretary is required to report to the Congress by April 1, 1988, on the advisability and feasibility of establishing a national fee schedule. ***(c) Payment for Travel Costs.***—Authorizes the Secretary to provide for and establish a fee to cover transportation and personnel expenses for trained personnel to travel to the location to collect the sample. Such fee may only be provided with respect to a beneficiary who is homebound or an inpatient in a facility other than a hospital. ***(d) State Standards for Directors of Clinical Laboratories.***—Specifies that clinical laboratories that meet State licensure laws regarding medical direction are qualified to receive payments under Medicare. ***Effective date.***—(a) applies to tests performed on or after January 1, 1987. (b) effective on enactment. (c) applies to samples collected on or after January 1, 1987. (d) effective January 1, 1987. ***Outlay effect*** (in millions): Fiscal years: 1987 ..... −10 1988 ..... −70 1989 ..... −90 3-year total ..... −170	No provision.

II. MEDICARE PROVISIONS (PART B)—Continued

Item	Present Law
29. Payment of Parenteral and Enteral Nutrition Supplies (Section 4529 of House bill)	Reasonable charges for medical services, supplies and equipment that, in the judgement of the Secretary, do not vary substantially in quality from one supplier to another may not exceed the lowest charge levels at which such services, supplies and equipment are widely and consistently available, except to the extent and under circumstances specified by the Secretary. Regulations implementing this provision established such lowest charge levels at the 25th percentile of the charges submitted for the item or service in question. Parenteral and enteral nutrition supplies and equipment are currently paid on the basis of reasonable charges.

House Bill	Senate Amendment
Requires the Secretary to apply the lowest charge level provision to parenteral and enteral nutrition supplies. ***Effective date.***—Applies to supplies on or after January 1, 1987. ***Outlay effect*** (millions): Fiscal years: 1987 ..... −35 1988 ..... −35 1989 ..... −40 3-year total ..... −110	No provision.

II. MEDICARE PROVISIONS (PART B)—Continued

Item	Present Law
30. Payment for Oxygen Therapy Services (Section 4530 of House bill)	Oxygen therapy services provided in the home are reimbursed on a reasonable charge basis under part B of Medicare. Payments for equipment are determined separately from payments for consumable oxygen. Total payments for consumable oxygen are determined by the amount of oxygen actually supplied.

House Bill	Senate Amendment
Requires the Secretary to establish monthly capitation fee schedules on a regional, statewide, or carrier service area basis for oxygen therapy services under part B. Payment shall be made on the basis of the number of units of oxygen prescribed by physicians, subject to verification by laboratory data or other means deemed appropriate by the Secretary. No payment may be made for services prescribed by a physician if the physician has significant ownership or financial interest in the entity supplying the oxygen therapy services, except with respect to sole suppliers as determined by the Secretary. The Secretary will provide for prompt payment of claims for oxygen therapy services (clean claims to be paid within 22 calendar days), or the carrier will pay interest on the amount payable. The carriers are to be reimbursed for their interest expense from amounts made available for Federal administrative expenses under part B. The Secretary shall establish the monthly capitation fee schedules based on 100 percent of the reasonable charge level for oxygen therapy services (excluding purchase or rental of equipment) for such services furnished in the region, State, or area for the 12 month period ending June 30, 1986. The fee schedules are to be adjusted annually, effective January 1 (beginning in 1987), by the percentage change in the Consumer Price Index for All Urban Consumers, subject to adjustments for technological changes and other factors as determined by the Secretary. The Secretary shall provide for a percentage increase in the fee schedule amounts for oxygen therapy services provided through a portable device. The Secretary shall also provide for a minimum monthly amount to assure the availability of such therapy for individuals consuming small amounts of oxygen.	No provision.

II. MEDICARE PROVISIONS (PART B)—Continued

Item	Present Law

House Bill	Senate Amendment
Program payment amounts are to be 80 percent of the amount determined under the monthly prospective fee schedule. In general, payment would only be made on the basis of assignment. ***Effective date.***—Applies to oxygen therapy services furnished on or after January 1, 1987. ***Outlay effect*** (in millions): Fiscal years: 1987 ..... −40 1988 ..... −60 1989 ..... −65 3-year total ..... −165	

II. MEDICARE PROVISIONS (PART B)—Continued

Item	Present Law
31. Changing Medicare Appeal Rights (Section 4532 of House bill)	Beneficiaries dissatisfied with a carrier's disposition of a part B claim are entitled to a review by the carrier. A fair hearing by the carrier is then available if the amount in controversy is $100 or more. The law does not provide for any further administrative appeal or judicial review for a part B claim.

House Bill	Senate Amendment
Provides that beneficiaries may obtain an administrative law judge hearing if the amount in controversy is $500 or more and judicial review if the amount in controversy is $1,000 or more. In determing the amount in controversy, the Secretary under regulations must allow two or more claims to be aggregated if the claims involve the delivery of similar or related services to the same individual or involve common issues of law and fact arising from services furnished to two or more individuals. Carrier hearings are retained for amounts in controversy between $100 and $500. Specifies that national coverage determinations made pursuant to section 1862(a)(1) of the Act are not subject to review by an administrative law judge but are subject to judicial review. ***Effective date.***—Applies to items and services furnished on or after January 1, 1987. ***Outlay effect*** (in millions) Fiscal years: 1987 ..... 4 1988 ..... 8 1989 ..... 8 3-year total 20	No provision.

II. MEDICARE PROVISIONS (PART B)—Continued

Item	Present Law
32. Alzheimer's Disease Demonstration Projects (Section 4533 of House bill)	Medicare beneficiaries with Alzheimer's disease or related disorders are covered for acute medical care services they might need. However, many of the home and community-based services which these persons require in order to remain in their homes are not covered by Medicare.

House Bill	Senate Amendment
Requires the Secretary of HHS to conduct at least 5 demonstration projects to determine the effectiveness, cost, and impact of providing comprehensive services to Medicare beneficiaries who are victims of Alzheimer's disease or related disorders. Services provided under the demonstration projects must be designed to meet the specific needs of Alzhemier's disease patients and may include case management, home and community-based services, mental health services, outpatient drug therapy, respite care and other supportive services and counseling for family, adult day care services and other in-home services. Each demonstration project would be conducted over a period of 3 years and at sites chosen so as to be geographically diverse and located in States with a high proportion of Medicare beneficiaries and in areas readily accessible to a significant number of Medicare beneficiaries. Requires that projects provide each Medicare beneficiary with a comprehensive medical and mental status evaluation upon entering the project and at discharge. Also requires that projects be conducted by entities which either directly or by contract are able to provide these evaluations and additional services covered. Projects also would be required to involve community outreach efforts at each site to enroll the maximum number of Medicare beneficiaries in each project. Requires the Secretary to waive compliance with Medicare requirements to the extent and for the period he finds necessary for the projects. Requires the Secretary to provide for an evaluation of the projects and to submit to Congress two reports: a preliminary report during the third year of the projects and a final report upon completion that includes recommendations for appropriate legislative changes.	No provision.

II. MEDICARE PROVISIONS (PART B)—Continued

Item	Present Law

House Bill	Senate Amendment
Specifies that expenditures not exeeed $40 million for the projects and $2 million for the evaluation and be made from the Federal Supplementary Medical Insurance Trust Fund. *Effective date.*—Enactment. *Outlay effect* (in millions): Fiscal years: 1987 ..... 14 1988 ..... 14 1989 ..... 14 3-year total 42	

Item	Present Law
33. Ambulatory Surgery (Section 624 of Senate amendment)	*Payment for Facility Services.*—Medicare may pay for ambulatory surgical procedures performed in three different settings: *Ambulatory Surgical Center (ASC).*—The Omnibus Reconciliation Act of 1980 (P.L. 96-499) authorized payments for facility services furnished in connection with ambulatory surgical procedures specified by the Secretary. Payments to ASCs are made on the basis of prospectively set rates known as the "standard overhead amount." On August 5, 1982, HHS issued final regulations and an accompanying notice identifying four groups of surgical procedures and the payment amount for each group. The payment amounts and the list of procedures has not been updated. The rates do not include payments for physicians' services, prosthetic devices, or laboratory services. No beneficiary cost-sharing is required. *Hospital Outpatient Department.*—Medicare payments for ambulatory surgery performed in a hospital outpatient department are made on the basis of reasonable costs. The standard Part B beneficiary cost-sharing is required. *Physician's Office.*—P.L. 96-499 also authorized payments to be made to physicians for the use of their office facilities when covered ambulatory surgical procedures were performed there. However, the legislation has not been implemented because adequate utilization and quality control peer review, which is required by law, is not available for office-based surgery. *Payment for Physicians' Services.*—When surgery is performed in any of these three settings, Medicare reimburses 100 percent of the physician's reasonable charge, provided the physician agrees to accept assignment.

House Bill	Senate Amendment
No provision.	*(a) Payment Rates.*—Provides that payments to hospital outpatient departments for procedures approved for ASCs, would be the lesser of the outpatient department's cost or the payment rate for the same surgical procedure in an ASC in the same geographic area. When the payment rate is based on the ASC payment rate, the outpatient department would receive additional payments for the cost of the services of certified nurse anesthetists (for cost reporting periods beginning before October 1, 1987) and for the direct costs of medical education. The Secretary is required to review and update the ASC payment rates not later than July 1, 1987, and annually thereafter, and to review and update the list of approved procedures not less than annually. *(b) Facility Services Definition.*—Specifies that "facility services" for which payment is made includes all "medical and other health services" furnished in connection with the procedure except the services of physicians. *(c) PRO Review.*—Requires Peer Review Organization contracts to provide for review of all ambulatory surgical procedures (or, at the Secretary's descretion, a sample of selected procedures) performed in ASCs and hospital outpatient departments. *(d) Coinsurance and Deductible to Apply Without Regard to Setting of Ambulatory Surgery.*—Repeals current law provisions waiving coinsurance and deductible requirements for ASC services and related physician services. *(e) Development of Prospective Payment Methodology for Outpatient Hospital Services.*—Requires the Secretary to develop groupings of pre- and postoperative services that are related to surgical services performed in a hospital outpatient department and then develop a model prospective reimbursement system that may be used for reimbursing hospitals under part B. The Secretary is required to report to Congress on the groupings and the model reimbursement system not later than January 1, 1991.

II. MEDICARE PROVISIONS (PART B)—Continued

Item	Present Law

House Bill	Senate Amendment
	(f) Study of Educational Activities.—Requires the Secretary to conduct a study on educational activities in hospital outpatient departments. The Secretary shall report the results to Congress not later than 2 years after enactment. *Effective date.*—The payment provisions in (a) apply to cost reporting periods beginning on or after July 1, 1987. (b) and (d) apply to services furnished after June 30, 1987. (c) applies to contracts entered into or renewed after January 1, 1987. All other provisions are effective on enactment. *Outlay effect* (in millions): Fiscal years: 1987 ..... —10 1988 ..... —125 1989 ..... —180 3-year total ..... —315

III. UTILIZATION AND QUALITY CONTROL PEER REVIEW

Item	Present Law
1. Peer Review Organizations (Section 10241 of House bill; Sections 631, 632, and 633 of Senate amendment)	*(a) PRO Review of Hospital Denial Notices.*—By regulation, hospitals are authorized to make determinations that further inpatient care is no longer medically necessary. If the attending physician concurs with this determination, the hospital may serve the beneficiary with a discharge notice and may begin to charge for continued stay beginning with the third day after serving the notice. The beneficiary may appeal the discharge notice to a peer review organization (PRO). If the PRO reverses the hospital's determination, the hospital may not bill for continued inpatient stay. The PRO is required to decide the appeal within 3 working days after receipt of the appeal. Under current policy, a beneficiary may incur financial liability for several days of continued stay before receiving notice of the PROs decision in the event of an adverse decision.

House Bill	Senate Amendment
(a) PRO Review of Hospital Denial Notices.—(i) Provides that if a hospital determines and the physician agrees that the patient no longer requires inpatient care, the hospital may provide that patient with a coverage denial notice.	*(a) PRO Review of Hospital Denial Notices.*—(i) Identical provision.
(ii) Provides that if a hospital has determined but the physician does not agree that the patient no longer requires inpatient care, the hospital may request the PRO to review the validity of the hospital's determination.	(ii) Identical provision.
(iii) Provides that if a patient has received a denial notice and requests the PRO to review the determination, the PRO shall conduct a review of the validity of the hospital's determination and shall provide notice to the patient, hospital, and attending physician. Such review is to be provided regardless of whether or not the hospital will charge for continued care or whether or not the patient will be liable for payment for continued care.	(iii) Similar provision. Specifies that the provision applies to requests made by a person who is still an inpatient. The PRO notice must be given to the patient within two calendar days after receipt of request. No PRO notice to hospital or attending physician is required.
(iv) Provides that if the patient requests a review while still an inpatient and not later than noon of the first working day after receipt of the hospital denial notice, the hospital must provide the PRO with the records required to review the determination by the close of business of such day, and the PRO must provide notice by not later than one full working day after it has received the request and the records.	(iv) No provision.
(v) Provides that if the patient has made a timely request, and the patient did not know and could not reasonably have been expected to know that continued inpatient stay was not necessary, the hospital may not charge the patient before noon of the day after receipt of the PRO's decision.	(v) Provides that if an inpatient makes a request for PRO review within 1 day after the date he or she receives the denial notice, the hospital may not charge the patient for services furnished before the fourth day after receipt of the denial notice.
(vi) Requires PRO's in conducting reviews to solicit the views of the patient.	(vi) Identical provision.

Item	Present Law
	(b) PRO Review of Inpatient Hospital Services and Early Readmission Cases.—PROs review the necessity and quality of hospital services provided to beneficiaries. (i) To initiate the review process, a PRO must receive data concerning the number and type of hospital discharges from hospitals in the PROs service area. This information is provided to PROs by Medicare fiscal intermediaries. There is no statutory provision regarding timely provision of data to PROs. (ii) Under PRO contracts for 1986–88, PROs will be required to review all readmissions to a hospital where the readmission occurs within 15 days after initial discharge.
	(c) Requiring PRO Review of Quality of Care.—PROs are required to review a sample of the professional activities of health care practitioners and providers for purposes of determining whether the services provided were medically necessary and meet professionaly recognized standards of care. COBRA required PROs to review services provided by health maintenance organizations (HMOs) and competitive medical plans (CMPs) effective January 1, 1987. A required level of effort for PRO review of HMO and CMP services is not specified.

ORGANIZATION (PRO) PROVISIONS—Continued

House Bill	Senate Amendment
(b) PRO Review of Inpatient Hospital Services and Early Readmission Cases.—	*(b) PRO Review of Inpatient Hospital Services and Early Readmission Cases.—*
(i) Requires the Secretary to provide that PROs receive each month either from hospitals or through fiscal intermediaries, data necessary to initiate the reviw process on a timely basis.	(i) Requires the Secretary to provide that fiscal intermediaries are to furnish the necessary data. If the Secretary determines that a fiscal intermediary is unable to furnish the information on a timely basis, he may require the hospital to do so.
(ii) Requires PROs to perform early readmission reviews to determine if the previous inpatient hospital services and post-hospital services met professionally recognized standards of health care. The reviews may be done on a sample basis if the PRO and Secretary determine it to be appropriate. An early readmission case is defined as one where a readmission occurs within 31 days of discharge.	(ii) Identical provision.
(c) Requiring PRO Review of Quality of Care.—	*(c) Requiring PRO Review of Quality of Care.—*
(i) Requires each PRO to provide that a reasonable proportion of its activities are involved with reviewing the quality of services and that a reasonable allocation of such activities is made among the different cases and settings (including inpatient hospital care, post-acute care settings, ambulatory settings, health maintenance organizations, and competitive medical plans). In establishing the allocation, the PRO shall consider: (1) whether there is reason to believe that there is need for review of particular cases or settings because of previous problems; (2) the cost and potential yield from reviews; and (3) the availability and adequacy of alternative quality review and assurance mechanisms.	(i) Similar provision respecting allocation of activities except specifies that the allocation among cases and settings is to be based on instances where potential problems of quality have been identified. Does not include provision relating to items the PRO must consider.
(ii) Requires each PRO contract to provide for review of inpatient and outpatient services provided by HMOs and CMPs to determine whether the quality of services meets professionally recognized standards of health care, including whether appropriate health services have not been provided or have been provided in inappropriate settings. The level of effort expended by PROs under this requirement shall be equivalent, on a per beneficiary basis, to that expended on utilization and quality reviews with respect to Medicare beneficiaries not enrolled in an HMO or CMP.	(ii) No provision.

Item	Present Law
	(d) Requiring Consumer Representation on PRO Boards.—No Provision.
	(e) Improve Peer Review Responsiveness to Beneficiary Complaints.—No provision.
	(f) Sharing of Information by PROs.—PRO confidential information is subject to protection.

ORGANIZATION (PRO) PROVISIONS—Continued

House Bill	Senate Amendment
(iii) Requires the Secretary, in consultation with appropriate experts, to identify methods that would be available to assist PROs in identifying those cases which are more likely than others to be associated with substandard quality.	(iii) Identical provision.
(d) Requiring Consumer Representation on PRO Boards.—Requires at least one consumer representative on PRO boards.	***(d) Requiring Consumer Representation on PRO Boards.***—No provision.
(e) Improve Peer Review Responsiveness to Beneficiary Complaints.—	***(e) Improve Peer Review Responsiveness to Beneficiary Complaints.***—
(i) Requires PRO's to conduct appropriate reviews of all written complaints by beneficiaries about the quality of services not meeting professionally recognized standards. The PRO is required to inform the beneficiary of its conclusions and final disposition.	(i) Similar provision. Specifies that the complaint and the name of the complainant shall be treated as confidential. The PRO is required to inform the individual that the organization has received the complaint and will take appropriate action.
(ii) Before the PRO concludes that the quality of care is substandard, it must provide the practitioner or person concerned with reasonable notice and opportunity for discussion.	(ii) No provision.
(f) Sharing of Information by PROs.—	***(f) Sharing of Information by PROs.***—
(i) Provides that confidential information, relating to a specific case or possible pattern of substandard care, obtained by PROs could be shared, upon request, with a State licensing or certification agency or with a national accreditation body, but only to the extent that such information is required by such agency or body to carry out official functions.	(i) Similar provision. Specifies information is related to a specific provider or practitioner. Provides that information can only be shared to the extent: (1) it relates to the quality of care provided; (2) the PRO determines it may reflect a failure in a substantial number of cases or a gross and flagrant failure in one or more instances to provide services meeting professionally recognized standards of health care; and (3) it is needed by the body in carrying out official duties.
(ii) Provides that confidential information obtained by PROs could be shared with State ombudsmen and State protection and advocacy officials, but only to the extent that such information is related to the quality of services furnished and only if the PRO determines that the information may reflect a failure in a substantial number of cases or a gross and flagrant failure in one or more instances to provide services of a quality which meets professionally recognized standards of health care. Further the information must be needed in connection with official duties.	(ii) No provision.

Item	Present Law
	(g) Funding of PRO Activities.—The costs of PRO review are funded by transfer of funds from the Federal Hospital Insurance Trust Fund. Under current law, the aggregate amount to be paid to all PROs during a year must be no less than the aggregate amount expended during FY 1986 on PRO reviews adjusted for inflation.

House Bill	Senate Amendment
(g) Funding of Additional PRO Activities.—Requires hospitals, skilled nursing facilities and home health agencies to maintain an agreement with the appropriate PRO with respect to review of services provided by hospitals, skilled nursing facilities or home health agencies (other than inpatient hospital services) and with respect to review of beneficiary complaints regarding quality. The activities are to be considered a cost of providing services and are to be paid directly by the Secretary to the PRO. Payments are to be transferred in appropriate amounts from the part A and part B trust funds and shall not be less in the aggregate than the amount determined by the Secretary to be sufficient to cover the costs of specified review activities. Similar provisions apply with respect to HMOs and CMPs.	*(g) Funding of Additional PRO Activities.*—No provision.
Effective date.—(a) Applies to denial notices furnished by hospitals to individuals on or after the first day of the first month that begins more than 30 days after enactment except that (a)(v) effective on enactment. (b)(i) Requires the Secretary to implement amendment not later than 6 months after the date of enactment. (b)(ii) Applies to contracts entered into or renewed on or after January 1, 1987. (c)(i) and (c)(ii) apply to contracts as of January 1, 1987 except that provision requiring equivalent PRO effort for HMOs and CMPs applies to review activities conducted on or after January 1, 1988. (c)(iii) Effective on enactment. (d) Applies to contracts entered into or renewed on or after January 1, 1987. (e) Applies to complaints received on or after the first day of the first month that begins more than 9 months after the date of enactment. (f) Applies to requests for data and information made on and after the end of the sixth month period beginning on the date of enactment. (g) Amendments apply to provider agreements as of October 1, 1987 and risk-sharing contracts with HMOs and CMPs as of January 1, 1987.	*Effective date.*—(a) Applies to denial notices furnished by hospitals to individuals on and after the first day of the first month that begins more than 30 days after enactment. (b)(i) Requires the Secretary to implement the amendment not later than six months after enactment. (b)(ii) Applies to contracts entered into or renewed after January 1, 1987. (c)(i) Applies to contracts entered into or renewed on or after January 1, 1987. (c)(iii) Effective on enactment. (e) Applies to complaints received on or after the first day of the first month that begins at least 9 months after the date of enactment. (f) Applies to data and information requests made on and after the end of the six-month period beginning on the date of enactment.
Total Outlay effect (in millions):	***Total Outlay effect*** (in millions):
Fiscal years: 1987 ..... 10 1988 ..... 17 1989 ..... 18 3-year total 45	Fiscal years: 1987 ..... 4 1988 ..... 7 1989 ..... 7 3-year total 18

IV. MEDICAID PROVISIONS

Item	Present Law
1. Optional Coverage for Poor Pregnant Women and Children (Section 4601 of House bill; Section 641 of Senate amendment)	States are required to provide Medicaid coverage to all children receiving assistance under the Federally-assisted Aid to Families with Dependent Children (AFDC) program and may provide coverage for children who would be eligible for AFDC except for income requirements (known as the medically needy). States are required to cover all children born after October 1, 1983 up to age 5 who meet the AFDC income and resources requirements and may extend coverage to all such children under age 5 immediately. States are also required to cover pregnant women meeting AFDC income and resources standards.

House Bill	Senate Amendment
(a) *New Optional Categorically Needy Group.*—	*(a) New Optional Categorically Needy Group.*—
(i) Creates a new optional categorically needy group composed of pregnant women (through 60 days following pregnancy) and infants up to 1 year of age with family incomes up to the Federal poverty level. A State choosing this option could not elect to cover only pregnant women or only children.	(i) Similar provision except that beginning in FY88 States could increase the age level by one in each fiscal year until all children up to age 5 were included. States could not elect to cover one age group unless children in all younger age groups were covered.
(ii) Provides that States could choose an income eligibility level between the AFDC payment level and 100 percent of the Federal poverty line. The State is required to use the same methodology used in determining eligibility for AFDC benefits. Costs incurred for medical care are not taken into account in determining eligibility.	(ii) Similar provision except does not specify that the minimum level is the AFDC level.
(iii) Prohibits States from setting a resource standard for newly eligible pregnant women. For infants, States are not permitted to apply a resource standard that is more restrictive than the AFDC standard; they are permitted to use the SSI resource standard, some other less restrictive resource test; or to impose no resources requirement at all.	(iii) Specifies that application of a resources standard is at State option. The State may choose the resource standard and methodology used under AFDC, SSI, or the medically needy programs; or it may choose to have no resource requirement.
(iv) Specifies that any different treatment of income and resources provided for newly eligible persons shall not require or permit such treatment for other persons.	(iv) Identical provision.
(v) Provides that if a State chooses to cover a new optional categorically needy group, it may not lower its AFDC payment levels below those in effect on April 17, 1986.	(v) Similar provision except linked to enactment.
(b) Benefits.—Specifies that newly covered pregnant women are only entitled to services related to pregnancy (including prenatal, delivery, and postpartum services) and to other conditions which may complicate pregnancy.	*(b) Benefits.*—Identical provision.

IV. MEDICAID PROVISIONS—Continued

Item	Present Law

House Bill	Senate Amendment
(c) Continuation of Assistance.—	*(c) Continuation of Assistance.—*
(i) Permits a State to treat a pregnant woman eligible under this provision as eligible for Medicaid throughout their pregnancy without regard to any change in family income.	(i) Identical provision.
(ii) Requires States to extend eligibility for an infant receiving inpatient services on his/her first birthday until the end of the inpatient episode.	(ii) Identical provision except also includes newly eligible children.
Effective date.—Applies to medical assistance furnished in calendar quarters beginning on or after July 1, 1987 without regard to whether final regulations have been promulgated by that date.	***Effective date.***—Except for the phased-in coverage of children, applies to medical assistance furnished in calendar quarters beginning on or after April 1, 1987. The phased-in coverage for children begins October 1, 1987 and is extended in 1 year intervals until October 1, 1990 when all newly eligible children under age 5 may be covered.
Outlay effect (in millions):	***Outlay effect*** (in millions):
Fiscal years: 1987 ..... 15 1988 ..... 75 1989 ..... 85 3-year total 175	Fiscal years: 1987 ..... 25 1988 ..... 85 1989 ..... 110 3-year total 220

Item	Present Law
2. Optional Presumptive Eligibility Period for Pregnant Women (Section 646 of Senate amendment)	Title XIX of the Social Security Act allows for a 3-month retroactive eligibility period prior to the date on which application for medical assistance is made. Medicaid regulations further require State agencies to determine eligibility within 45 days from the day of the application for benefits. If the application is approved, medical expenses incurred during the 3-month retroactive eligibility period and services incurred after the date of application for benefits are reimbursed under the normal Medicaid rules. If the application is denied, medical expenses incurred during the 3-month retroactive eligibility period and services incurred after the date of application remain the responsibility of the individual.

House Bill	Senate Amendment
No provision.	Permits States to make ambulatory prenatal care available to pregnant women during a presumptive period of eligibility which is defined as: (1) beginning on the date on which a qualified provider determines on the basis of preliminary information that the family income falls below the applicable Medicaid standard; and (2) ending on the earlier of the day on which the application is approved or disapproved by the State agency or 45 days after the date the provider makes the determination. A qualified provider (1) is eligible for Medicaid payments; (2) provides outpatient hospital services, rural health services, or clinic services; (3) is determined by the State agency to be capable of making presumptive eligibility determinations; and (4) receives funds under the migrant health centers, community health centers, or the maternal and child health block grant programs; participates under the Special Supplemental Food Program for Women, Infants and Children or the Commodity Supplemental Food Program; or participates in a State perinatal program. The State agency is required to provide qualified providers with necessary application forms and information on how to assist pregnant women to complete the forms. A provider that determines a woman is presumptively eligible is required to notify the State agency within 5 working days of the determination. The provider also must inform the woman at the time the determination is made that she is required to apply for Medicaid within 14 days of the determination, and the woman is required to make such application. Payments made on behalf of presumptively eligible women shall be at the same rate otherwise applicable. The amounts of any excess payments under this provision are not to be included toward the calculation of excess payments under the State's quality control program. *Effective date.* —Applies to ambulatory prenatal care furnished in calendar quarters beginning on or after April 1, 1987. *Outlay effect* (in millions) Fiscal years: 1987 ..... 2 1988 ..... 2 1989 ..... 2 3-year total 6

IV. MEDICAID PROVISIONS—Continued

Item	Present Law
3. Optional Coverage of Elderly and Disabled Poor for All Medicaid Benefits (Section 4602 of House bill; Section 642(a) of Senate amendment)	Eligibility of the elderly and the disabled for Medicaid is linked to actual or potential receipt of cash assistance under the Federal Supplemental Security Income (SSI) program. The elderly and the disabled covered under Medicaid generally are persons receiving Federal and/or State SSI payments, residing in a skilled nursing facility or intermediate care facility, or incurring substantial medical expenses. The income and resource eligibility criteria differ substantially among the States.

House Bill	Senate Amendment
(a) New Optional Categorically Needy Group.—Creates a new optional categorically needy group composed of the aged and disabled with family incomes up to the Federal poverty level. A State choosing this option would have to offer the benefit package available to other categorically needy recipients. A State choosing this option would also have to cover some newly eligible pregnant women and children.	*(a) New Optional Categorically Needy Group.*—Identical provision.
(b) Income and Resources Standards.—Provides that States could choose an income eligibility level up to 100 percent of the Federal poverty line. Costs incurred for medical care are not taken into account in determining eligibility. Requires States to use SSI resource standards, except that if a State has a medically needy program utilizing higher resource standards, it may utilize those higher standards. Specifies that any different treatment of income and resources provided for newly eligible persons shall not require or permit such treatment for other persons.	*(b) Income and Resources Standards.*—Identical provision.
Effective date.—Applies to payments to States for calendar quarters beginning on or after July 1, 1987 without regard to whether final regulations have been promulgated by that date.	*Effective date.* —Applies to payments to States for calendar quarters beginning on or after July 1, 1987 without regard to whether final regulations have been promulgated by that date.
Outlay effect (in millions):	*Outlay effect* (in millions):
Fiscal years: 1987 ..... 30 1988 ..... 100 1989 ..... 140 3-year total 270	Fiscal years: 1987 ..... 30 1988 ..... 100 1989 ..... 140 3-year total 270

IV. MEDICAID PROVISIONS—Continued

Item	Present Law
4. Optional Coverage of Poor Medicare Beneficiaries for Medicare Cost-Sharing Expenses (Section 4603 of House bill and Section 642(b) of Senate amendment)	Coverage under Medicare part B requires payment of a monthly premium. Most States make this payment for their Medicaid eligibles under a "buy-in" agreement. While States may buy in to Medicare for both their cash assistance and non-cash assistance populations who are eligible for Medicare, Federal matching for premium payments is only available for the cash assistance group. States may receive Federal matching payments for Medicare cost-sharing charges, including deductibles and coinsurance, for services provided to their dual eligibles.

House Bill	Senate Amendment
(a) New Optional Coverage Group for Medicare Cost-Sharing.—	*(a) New Optional Coverage Group for Medicare Cost-Sharing.*—Identical provision.
(i) Creates a new optional coverage group composed of Medicare part A beneficiaries not otherwise eligible for Medicaid with family incomes up to the Federal poverty level. A State choosing this option would also have to cover some newly eligible pregnant women and children.	
(ii) Provides that States could choose an income eligibility level up to 100 percent of the Federal poverty line. Costs incurred for medical care are not taken into account in determining eligibility.	
(iii) Requires States to use SSI resource standards, except that if a State has a medically needy program utilizing higher resource standards, it may utilize those higher standards.	
(iv) Specifies that any different treatment of income and resources provided for newly eligible persons shall not require or permit such treatment for other persons.	
(b) Benefits.—Specifies that covered benefits are limited to Medicare cost-sharing. Medicare cost-sharing is defined as part B premiums, part A deductibles and coinsurance, part B deductibles and part B coinsurance. The term may include, at the option of the State, premiums for enrollment of an eligible beneficiary with a Medicare-qualified risk-sharing HMO.	*(b) Benefits.*—Identical provision except includes (if applicable) part A premiums.
(c) Payment Amounts.—Provides that the total of Medicaid payments for Medicare cost-sharing charges under this provision together with Medicare payments may exceed the amounts otherwise payable under the State Medicaid plan for such services.	*(c) Payment Amount.*—Identical provision.
(d) Effective Date of Benefits.—Specifies that if an individual is determined to be a qualified Medicare beneficiary as defined under this provision, the determination shall apply to services furnished after the end of the month in which the determination first occurs. The determination shall be considered to be valid for a 12-month period, except that a State may provide for more frequent determinations but not more frequently than every six months.	*(d) Effective Date of Benefits.*—Identical provision.

IV. MEDICAID PROVISIONS—Continued

Item	Present Law

House Bill	Senate Amendment
Effective date.—Applies to payments under Medicaid for calendar quarters beginning on or after July 1, 1987 without regard to whether final regulations have been promulgated by that date.	***Effective date.***—Applies to payments under Medicaid for calendar quarters beginning on or after July 1, 1987 without regard to whether final regulations have been promulgated by that date.
Outlay effect (in millions):	***Outlay effect*** (in millions):
Fiscal years:	Fiscal years:
1987 15	1987 15
1988 70	1988 70
1989 100	1989 100
3-year total 185	3-year total 185

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IV. MEDICAID PROVISIONS—Continued

Item	Present Law
5. Medicaid Eligibility for Qualified Severely Impaired Individuals (Section 4604 of House bill)	Low-income individuals who qualify for Medicaid on the basis of disability must, in most States, meet the disability standards of the Supplemental Security Income (SSI) program. (Some States have opted to impose more restrictive disability criteria than those in SSI. These are commonly referred to as the "209(b) States" in reference to the statutory provision which gives them the option to use their 1972 eligibility standards for the elderly and disabled). For purposes of SSI, an individual is not considered to be disabled if, after a 9-month trial work period, he or she is able to engage in "substantial gainful activity" (SGA), which the Secretary has defined as average counted earnings of over $300 per month. Loss of disabled status for SSI purposes means loss of categorical eligibility for Medicaid. The Disability Amendments of 1980 (P.L. 96-265) added a new section 1619 to the SSI law. Section 1619(a) provides that an individual who loses eligibility for SSI because he or she has worked and demonstrated the ability to engage in SGA, but who continues to have a disabling impairment, may become eligible for special SSI benefits until his or her countable income reaches the SSI income disregard "break-even" point ($756 per month in 1986 in a State with no supplementation). Those who qualify for these special SSI benefits continue to be eligible for Medicaid as long as they need medical assistance to continue working. Section 1619(b) provides Medicaid coverage for individuals whose earnings exceed the SSI income disregard "break-even point." This special Medicaid eligibility status applies so long as the individual: (1) continues to be blind or have a disabling impairment; (2) except for earnings, continues to meet all the other requirements for SSI eligibility; (3) would be seriously inhibited from continuing to work by the loss of Medicaid coverage; and (4) has earnings that are not sufficient to provide a reasonable equivalent of the Medicaid and SSI benefits that would have been available if he or she did not work. The Social Security Administration (SSA) has established a "threshold" in each State based on SSI and State supplementary payment levels and the State's average per capita Medicaid expenditures; individuals with gross earnings in excess of this "threshold" no longer meet requirement

House Bill	Senate Amendment
Amends Title XIX of the Social Security Act to establish a new mandatory, categorically needy coverage group: "qualified severely impaired individuals." This group includes any individual under 65 who received either SSI, State supplementation, or special 1619(a) benefits and who: (1) continues to be blind or have a disabling physical or mental impairment; (2) except for earnings, continues to meet all other requirements for SSI eligibility (including having unearned income below the SSI benefit standard); (3) would be seriously inhibited by the lack of Medicaid coverage from continuing to work or from obtaining employment; and (4) has earnings that are not sufficient to provide a reasonable equivalent of the Medicaid, SSI and Title XX attendant care benefits that would be available if he or she did not work. This mandatory coverage group applies both in States that currently follow the SSI definition of disability and in the "209(b)" States.	No provision.

IV. MEDICAID PROVISIONS—Continued

Item	Present Law
	(4) and therefore lose Medicaid coverage, unless their individual medical expenses exceed the State's average Medicaid expenditures. According to the Social Security Administration, section 1619 has enabled nearly 9,000 former SSI recipients to retain Medicaid coverage despite returning to work and performing SGA. This section expires on June 30, 1987.

House Bill	Senate Amendment
Effective date.—Applies to payments for calendar quarters beginning on or after July 1, 1987, without regard to whether regulations to implement these amendments have been promulgated by such date. Delay would be permitted where State legislation is required to amend the State's Medicaid plan. ***Outlay effect.***—None.	

IV. MEDICAID PROVISIONS—Continued

Item	Present Law
6. Clarification of Eligibility of Homeless Individuals (Section 4605 of House bill)	States are prohibited from imposing residency requirements that exclude any otherwise qualified individual who resides in the State. There is no Federal requirement that an individual have a fixed or permanent residence in order to qualify for Medicaid. However, according to the Department of Health and Human Services and the General Accounting Office, some States and localities require applicants for Medicaid and AFDC to supply a fixed address in order to qualify. It appears that these requirements are imposed out of concern by the States that the Federal government will penalize them if they approve fraudulent applications for homeless recipients.

House Bill	Senate Amendment
Clarifies that States or localities are prohibited from imposing any residence requirement which excludes from Medicaid any otherwise qualified individual who resides in the State, regardless of whether or not the residence is maintained permanently or at a fixed address. *Effective date.*—Enactment. *Outlay effect.*—None.	No provision.

IV. MEDICAID PROVISIONS—Continued

Item	Present Law
7. Treatment of Income and Resources Required to be Paid under Spousal and Child Support (Section 4606 of House bill)	Medicaid statute provides that, in determining eligibility, States take into account only such income and resources as are available to the applicant or recipient, in accordance with standards prescribed by the Secretary.

House Bill	Senate Amendment
Clarifies that in determining the income and resources of an individual who is in an institution, the individual shall not be considered to have available to him or her income or resources which are required to be paid under court order for the support of the individual's spouse or child. *Effective date.*—Applies to States which had the policy or practice of disregarding such support payments in such circumstances as of July 22, 1986, without regard to whether or not the policy or practice, reflected in a State plan amendment or not, was approved by HCFA. *Outlay effect.*—None.	No provision.

Item	Present Law
8. Payment for Aliens Under Medicaid (Section 4607 of House bill)	Medicaid statute does not explicitly identify whether otherwise qualified aliens are entitled to benefits. By regulation, the Secretary has limited Medicaid eligibility to otherwise eligible aliens who are lawfully admitted for permanent residence or permanently residing in the U.S. under color of law, including any alien who is lawfully present under sec. 203(a)(7) or sec. 212(d)(5) of the Immigration and Nationality Act. The Aid to Families with Dependent Children (AFDC) statute, section 402(a)(33) of the Social Security Act, and the Supplemental Security Income (SSI) statute, section 1614(a)(1)(B) of the Act, both limit eligibility for cash assistance benefits to otherwise qualified aliens who are lawfully admitted for permanent residence or otherwise permanently residing in the U.S. under color of law. On July 14, 1986, a U.S. District Court struck down this regulation as outside the scope of the authority delegated under the Medicaid statute. The court reasoned that Congress "knew how to impose alienage requirements on social welfare programs when it intended, and its refusal to impose such a requirement on Medicaid should be respected." Because the AFDC and SSI statutes do include explicit exclusions of certain classes of aliens, the result of this decision is that otherwise qualified aliens who are eligible for Medicaid as non-cash beneficiaries—i.e., medically needy or optional categorically needy individuals—are entitled to Medicaid coverage.

House Bill	Senate Amendment
Amends the Medicaid statute at section 1903(i) to make it explicit that Federal financial participation is not available for State expenditures for aliens who are not lawfully admitted for permanent residence or permanently residing in the U.S. under color of law. Also provides in sec. 1902(a) that nothing in Medicaid law should be construed to require a State to offer coverage to aliens who are not lawfully admitted for permanent residence or otherwise permanently residing in the U.S. under color of law. *Effective date.*—Amendment at section 1903(i) applies to medical assistance furnished to aliens on or after January 1, 1987. Amendment to 1902(a) applies to medical assistance furnished to individuals on or after date of enactment. *Outlay effect.*—None.	No provision.

Item	Present Law
9. Permitting States to Offer Home and Community-Based Services to Low-Income Individuals with AIDS or AIDS-Related Conditions (Section 4611 of House bill)	***(a) Eligibility for Persons with AIDS or AIDS-Related Conditions.***—Section 1915(c) authorizes the Secretary to waive certain Medicaid requirements to allow States to provide a variety of home and community-based long-term care services to individuals (1) who would otherwise require the level of care provided in a SNF or ICF whose cost could be reimbursed under the State plan, or (2) who but for the provision of these services would continue to receive inpatient hospital, SNF, or ICF services because they are dependent on ventilator support whose cost is reimbursed under the State plan. ***(b) Computing Expenditures for AIDS Patients.***—In order to receive approval for a waiver, States must provide a number of assurances to the Secretary, including one requiring that the estimated average per capita expenditure for medical assistance under the waiver for those receiving waivered services in any fiscal year not exceed 100 percent of the average per capita expenditure that the State reasonably estimates would have been incurred in that year for that population if the waiver had not been granted. COBRA allowed States, in estimating average per capita expenditures for waivers applying only to physically disabled individuals in SNFs or ICFs, to use only the expenditures associated with this group of persons and not expenditures associated with other eligible individuals. ***(c) Providing Case Management Services to AIDS Patients.***—Section 1915(g) authorizes the Secretary to provide case management services without regard to requirements that Medicaid services be available throughout a State and that covered services be equal in amount, duration, and scope for certain Medicaid recipients. Case management services are defined as services which will assist individuals eligible under the State's Medicaid plan in gaining access to needed medical, social, educational, and other services.

House Bill	Senate Amendment
(a) Eligibility for Persons with AIDS or AIDS-Related Conditions.—Extends eligibility for home and community-based services to individuals diagnosed as having AIDS or AIDS-related conditions whose cost of treatment is reimbursed under the State plan.	No provision.
(b) Computing Expenditures for AIDS Patients.—Allows States, in estimating average per capita expenditures for waivers applying only to persons with AIDS or AIDS-related conditions who are in hospitals, SNFs, or ICFs, to use only the expenditures associated with this group of persons and not expenditures associated with other individuals in these facilities.	
(c) Providing Case Management Services to AIDS Patients.—Allows States to limit the provision of case management services under section 1915(g) to individuals with AIDS or AIDS-related conditions.	
Effective date.—Applies to applications for waivers (or renewals thereof) approved on or after date of enactment.	
Outlay effect.—None.	

IV. MEDICAID PROVISIONS—Continued

Item	Present Law
10. Permitting States to Offer Home and Community-Based Services to Low-Income Individuals with Chronic Mental Illness (Section 4612 of House bill)	***(a) Eligibility for Persons with Chronic Mental Illness.***—Section 1915(c) authorizes the Secretary to waive certain Medicaid requirements to allow States to provide a variety of home and community-based services to individuals (1) who would otherwise require the level of care provided in a SNF or ICF whose cost could be reimbursed under the State plan, or (2) who but for the provision of these services would continue to receive inpatient hospital, SNF, or ICF services because they are dependent on ventilator support whose cost is reimbursed under the State plan. ***(b) Computing Expenditures for Patients with Chronic Mental Illness.***—In order to receive approval for a waiver, States must provide a number of assurances to the Secretary, including one requiring that the estimated average per capita expenditure for medical assistance under the waiver for those receiving waivered services in any fiscal year not exceed 100 percent of the average per capita expenditure that the State reasonably estimates would have been incurred in that year for that population if the waiver had not been granted. COBRA allowed States, in estimating average per capita expenditures for waivers applying only to physically disabled individuals in SNFs or ICFs, to use only the expenditures associated with this group of persons and not expenditures associated with other eligible individuals in these facilities. ***(c) Providing Case Management Services to Patients with Chronic Mental Illness.***—Section 1915(g) authorizes the Secretary to provide case management services without regard to requirements that Medicaid services be available throughout a State and that covered services be equal in amount, duration, and scope for certain Medicaid recipients. Case management services are defined as services which will assist individuals eligible under the State's Medicaid plan in gaining access to needed medical, social, educational, and other services.

House Bill	Senate Amendment
(a) Eligibility for Persons with Chronic Mental Illness.—Extends eligibility for home and community-based services to persons with chronic mental illness whose treatment is reimbursed under the State plan. Also clarifies with a technical amendment that plan requirements which may be waived under section 1915(c) include comparability of covered services, i.e., that covered services be equal in amount, duration, and scope for certain Medicaid recipients.	No provision.
(b) Computing Expenditures for Patients with Chronic Mental Illness.—Allows States, in estimating average per capita expenditures for waivers applying only to persons with chronic mental illness who are in hospitals, SNFs, or ICFs, to use only the expenditures associated with this group of persons and not expenditures associated with other persons in these facilities.	
(c) Providing Case Management Services to Patients with Chronic Mental Illness.—Allows States to limit the provision of case management services under section 1915(g) to individuals with chronic mental illness.	
Effective date.—Applies to applications for waivers (or renewals thereof) approved on or after date of enactment.	
Outlay effect.—None.	

IV. MEDICAID PROVISIONS—Continued

Item	Present Law
11. Waiver Authority for the Chronically Medically Ill Demonstration Program (Section 4613 of House bill)	The Robert Wood Johnson Foundation and the Department of Housing and Urban Development (HUD) will jointly fund a 5-year demonstration "Program for the Chronically Mentally Ill." Grants and low-interest loans will be available to eight urban centers with populations in excess of 250,000 to assist in the establishment of a comprehensive system of care and rehabilitation and the expansion of housing options for chronically mentally ill persons. Grantees with approved housing plans will also be eligible for Federal rent subsidy assistance from HUD. HUD will pay the difference between the equivalent of 30 percent of the income of low-income individuals and locally established fair market rents. Robert Wood Johnson plans to announce the recipients of grants on November 1, 1986.

House Bill	Senate Amendment
Authorizes the Secretary of HHS to waive certain Medicaid requirements to allow States to implement demonstration programs to improve the continuity, quality, and cost-effectiveness of mental health services available to chronically mentally ill Medicaid beneficiaries. Medicaid requirements which may be waived under this program include Statewideness, comparability, freedom of choice, review and screening of care, and certain requirements pertaining to entities providing care on a prepaid capitation basis. Requires that a waiver be granted only if: (1) the demonstration program is receiving funding from the Robert Wood Johnson Foundation and HUD under the "Program for the Chronically Mentally Ill," (2) the State provides assurances to the Secretary of HHS that the estimated average per capita expenditure for medical assistance for mental health provided in any fiscal year to persons covered under the program does not exceed 100 percent of the average per capita expenditure that the State reasonably estimates would have been incurred in that year for such persons if the waiver had not been granted, and (3) the State provides assurance that there will be no reduction or limitation in benefits to a Medicaid beneficiary under the program. States may cover the following services under waivers: case management services for mentally ill patients, habilitation services (as defined in section 1915(c)(5) of Medicaid), day treatment or other partial hospitalization services, residential services (other than room and board), psychosocial rehabilitation services, clinic services (whether or not furnished in a facility), and such other services as the State may request and the Secretary may approve for individuals covered under the demonstration. Requires that a waiver be granted for an initial term of 3 years which may be extended for an additional 2-year term. The request for an extension shall be deemed granted unless the Secretary denies the request in writing within 90 days after submission. The authority for the	No provision.

IV. MEDICAID PROVISIONS—Continued

Item	Present Law

House Bill	Senate Amendment
Secretary of HHS to approve a waiver would extend only during the 5-year period beginning October 1, 1986. Prohibits the Secretary from requiring, as a condition for approving a waiver, that the actual total expenditures for services provided under the waiver (and the associated claim for Federal matching payments) cannot exceed approved estimates for services. Nor could the Secretary deny Federal matching payments for services on the ground that a State has failed to limit actual total expenditures for services under the waiver to approved estimates for these expenditures. Requires the Secretary to monitor the implementation of waivers to assure that requirements are met and to terminate any waiver, after notice and opportunity for a hearing, where he finds noncompliance has occured. Requires the Secretary to report to Congress, not later than Jan. 1, 1993, on the cost, accessibility, utilization, and quality of services provided under these waivers. *Effective date.*—Enactment. *Outlay effect.*—None.	

IV. MEDICAID PROVISIONS—Continued

Item	Present Law
12. Continuation of "Case-Managed Medical Care for Nursing Home Patients" Demonstration Project (Section 4614 of House bill)	Section 222 of the Social Security Amendments of 1972, section 402(a) of the Social Security Amendments of 1967, and section 1115 of the Social Security Act provide the Secretary of HHS general authority to conduct experiments and demonstrations on Medicare and Medicaid alternative payment systems and benefits and to waive compliance with various program requirements in conducting these demonstrations. Under this authority, the Secretary has approved Medicare and Medicaid waivers for the demonstration project, "Case-Managed Medical Care for Nursing Home Patients," for the period July 1983 through July 1986. These waivers were granted to the Massachusetts Department of Public Welfare to permit fee-for-service reimbursement for the provision of medical services by physician-supervised nurse practitioners/physician assistants for 6,500 residents of nursing homes. Under this demonstration, increased medical monitoring is expected to generate cost savings as a result of fewer hospital admissions and hospital outpatient visits. HCFA's Office of Research and Demonstration extended this project through June 1987.

House Bill	Senate Amendment
Requires the Secretary to approve applications for waivers for continuation of "Case-Managed Medical Care for Nursing Home Patients" for the period July 1, 1987 through June 30, 1989, and to continue the approval on the same terms and conditions as applied to the project on July 1, 1986. *Effective date.*—Enactment. *Outlay effect.*—None.	No provision.

Item	Present Law
13. Holding States Harmless in Fiscal Year 1987 Against a Decrease in the Federal Medical Assistance Percentage (Section 4621 of House bill; Section 644 of Senate amendment)	COBRA provided that beginning in fiscal year 1987, the Federal Medical Assistance Percentage (FMAP) is to be calculated on an annual rather than a biennial basis. The FMAP, which represents the Federal share of Medicaid expenditures in the State, is tied to a formula inversely related to the per capita income of the States.

House Bill	Senate Amendment
Provides that the change to the annual calculation shall not apply to a State Medicaid program for calendar quarters occurring in FY87 if the State would be adversely affected by the change.	Identical provision.
Effective date.—Effective as though included in COBRA at the time of its enactment.	***Effective date.***—Effective as though included in COBRA at the time of its enactment.
Outlay effect (in millions):	***Outlay effect*** (in millions):
Fiscal year: 1987 ..... 50 1988 ..... 0 1989 ..... 0 3-year total 50	Fiscal years: 1987 ..... 50 1988 ..... 0 1989 ..... 0 3-year total 50

IV. MEDICAID PROVISIONS—Continued

Item	Present Law
14. Independent Quality Review of HMO Services (Section 4631 of House bill)	Regulations require that entities which serve Medicaid beneficiaries on a prepayment basis must have internal quality assurance systems meeting certain specifications. Under Medicare, services provided by risk contracting HMOs and CMPs are subject to review by utilization and quality control peer review organizations (PROs) effective January 1, 1987.

House Bill	Senate Amendment
Requires the States to provide for an annual, independent, external review of Medicaid services rendered under prepayment and risk sharing contracts. Such review is to be performed by either a PRO or other private accreditation body. The results of such reviews are to be made available to the State and, upon request, to the Secretary, the Inspector General of the Department of Health and Human Services, and the Comptroller General. *Effective date.*—Applies to payments under title XIX for calendar quarters beginning on or after July 1, 1987, without regard to whether or not final regulations to carry out the provision have been promulgated by such date. *Outlay effect.*—Negligible.	No provision.

IV. MEDICAID PROVISIONS—Continued

Item	Present Law
15. Clarification of Flexibility in State Utilization Review Systems (Section 4632 of House bill)	States may at their option implement second surgical opinion programs or hospital preadmission review programs. DHHS has proposed a rule which would require every State to have in place by January 1, 1987, a mandatory second surgical opinion program, or as an alternative, an existing utilization review plan that prevents unnecessary surgery, is cost-effective and meets the Department's approval.

House Bill	Senate Amendment
(a) Clarification.—Specifies that nothing in the Medicaid law is to be construed as authorizing the Secretary to require that States operate second surgical opinion programs or inpatient hospital preadmission review programs. *(b) Report.*—Requires the Secretary to report to Congress not later than January 1, 1992 for each State in a representative sample of States on: (1) the high volume or high cost procedures used by Medicaid patients; (2) payment rates and aggregate spending rates for these procedures; (3) the extent of geographic variation in the rate of performance of such procedures; (4) the rate at which the procedure is performed on Medicaid patients compared to private patients; and (5) the number of physicians willing and qualified to perform second opinions for such procedures. The report is to include: (1) a list of procedures which the Secretary believes a mandatory second opinion may be appropriate; and (2) an identification of underutilized Medicaid procedures. *Effective date.*—Enactment. *Outlay effect.*—None.	No provision.

IV. MEDICAID PROVISIONS—Continued

Item	Present Law
16. Clarification of Flexibility for State Medicaid Payment Systems for Inpatient Services (Section 4633 of House bill)	States are required to provide assurances to the Secretary that their Medicaid plans' payments for hospital, SNF, and ICF services are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with State and Federal laws, regulations, and quality and safety standards and to assure that individuals eligible for medical assistance have reasonable access to inpatient hospital services of adequate quality. On February 18, 1986, HCFA published a proposed regulation which would limit payments for inpatient hospital services or long-term care facility services to hospitals, SNFs, ICFs, and ICFs/MR to the amount that can reasonably be estimated would have been paid for the services under Medicare reimbursement principles in effect at the time the services were furnished.

House Bill	Senate Amendment
Clarifies that nothing in Medicaid statute should be construed as authorizing the Secretary to limit the amount of payment that may be made for inpatient hospital services, SNF, or ICF services, including any limitation based on Medicare's reimbursement principles. *Effective date.*—As though it were included in OBRA of 1981, P.L. 97-35. *Outlay effect*—None.	No provision.

Item	Present Law
17. Financial Disclosure Requirements for HMOs (Section 4634 of House bill)	***(a) Disclosure of Interlocking Relationships.***—All entities furnishing services under Medicaid must disclose to the State the identity of each person with a control interest or with an ownership interest of 5 percent or more. In addition, participating providers must disclose, upon request by the State or the Secretary, full and complete information as to the ownership of a subcontractor with whom the entity has had business transactions in excess of $25,000 per year, and as to any significant business transactions with such subcontractor. Title XIII of the Public Health Service Act, under which Health Maintenance Organizations (HMOs) may become federally qualified, provides that such plans must report to the Secretary a description of transactions between the HMO and a party in interest, and shall make such information available to its members upon reasonable request. ***(b) Approval of Contractual Expenditures.***—Prior to 1983, HCFA regulations required prior approval of the regional Medicaid director of contracts with HMOs exceeding $100,000.

House Bill	Senate Amendment
(a) Disclosure of Interlocking Relationships.—Requires that each entity that is contracting with a State to provide services to Medicaid beneficiaries on a capitated or risk basis that is not also a federally qualified HMO under the Public Health Service Act, must report to the State, and on request to the Secretary, the Inspector General of the Department of Health and Human Services and the Comptroller General, a description of transactions between the organization and party in interest. Transactions that must be reported include: (i) any sale, exchange or leasing of property; (ii) any furnishing for consideration of goods, services or facilities (but not salaries paid to employees); and (iii) any loans or extensions of credit. Each organization shall make the information reported available to its enrollees upon reasonable request.	No provision.
(b) Approval of Contractual Expenditures.—Requires that the Secretary must provide prior approval of contracts in excess of $100,000 between States and entities contracting to provide services to Medicaid beneficiaries on a capitated or risk contracting basis. *Effective date.*—Financial disclosure provision is effective 6 months after enactment. Approval of contractual expenditures provision is effective on enactment and applies to contracts entered into, renewed or extended after the end of the 30 day period beginning on enactment. *Outlay effect.*—None.	

IV. MEDICAID PROVISIONS—Continued

Item	Present Law
18. Delegation to Inspector General of Authority Over State Medicaid Fraud Control Units (Section 4635 of House bill)	Federal administrative responsibility for State Medicaid Fraud Control Units was transferred to the Office of Inspector General in 1979.

House Bill	Senate Amendment
Provides that Secretary shall provide for the delegation of the Secretary's authority over State Medicaid Fraud Control Units to the Office of the Inspector General. *Effective date.*—Enactment. *Outlay effect.*—None.	No provision.

IV. MEDICAID PROVISIONS—Continued

Item	Present Law
19. COBRA Technical Corrections and Clarifications Relating to the Medicaid Program (Section 4636 of House bill)	The Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99–272) was signed into law April 7, 1986. COBRA contains a number of technical errors.

House Bill	Senate Amendment
(a) Trusts.—Clarifies that section 9506 of COBRA, regarding the treatment of income tax from certain trusts, does not apply to certain trusts established before April 7, 1986 solely for the benefit of residents in an intermediate care facility for the mentally retarded. *(b) Health Insurance Organizations.*—Clarifies that section 9517(c)(2) of COBRA, regarding the applicability of certain contracting requirements to prepaid plans, shall not apply to the Hartford Health Network, Inc. *(c) Other Technical Corrections and Clarifications.*—Makes technical corrections and clarifications to COBRA relating to Medicaid errors. *Effective date.*—Applies as if included in the enactment of COBRA. *Outlay effect.*—None.	No provision.

Item	Present Law
20. Payment of Certain Long-Term Care Patients in Hospital (Section 4638 of House bill)	A State may reimburse hospitals for inpatient services rendered to Medicaid-eligible patients who no longer need acute hospital care, who do need skilled nursing facility (SNF) or intermediate care facililty (ICF) level of care, but for whom such services are unavailable due to shortage of nursing home beds in the community. The rate of payment for such patients awaiting long-term care placement is the estimated State-wide average rate per patient day for SNF services rather than the hospital's inpatient acute care rate, with one exception. The State may choose to pay the higher inpatient hospital rate for such inappropriately-placed patients if there are no excess beds in the hospital *and* in the area where the hospital is located. Under HCFA regulations, a hospital or area has excess beds if its occupancy rate is under 80 percent.

House Bill	Senate Amendment
Allows the State of New York under its Medicaid plan to pay for services rendered to hospital patients who are awaiting long-term care placement at the higher acute care rate if either the facility *or* the region has an occupancy rate of 80 percent of more, but only if the Secretary of HHS determines that the State has decertified a sufficient number of hospital beds to offset the additional costs resulting from the higher payment rate. ***Effective date.***—Applies to payments for services furnished during the 3-year period beginning Jan. 1, 1986, after the date the Secretary makes the determination described above. ***Outlay effect.***—None.	No provision.

Item	Present Law
21. Respiratory Care Services for Ventilator-Dependent Individuals (Section 643 of the Senate amendment)	There is no direct provision for home respiratory services defined in the Medicaid statute. Medicaid could pay for home respiratory services at the option of the State in three ways: (1) as home health care services if the State considers home respiratory services as a medically necessary component of home health care services (2) as services provided to disabled children under 18, but only if the services cost no more than institutional care and only if all disabled children meeting certain criteria are covered under this optional service; and (3) as home- and community-based services.

House Bill	Senate Amendment
No provision.	Requires States to cover respiratory services in the home for individuals who (1) are medically dependent on a ventilator for life support at least 6 hours per day; (2) have been so dependent for at least 30 consecutive days or the maximum number of the days authorized under the State plan, whichever is less, as inpatients; (3) but for home respiratory care, would require respiratory care on an inpatient basis for which Medicaid would pay (4) have adequate social support services to be cared for at home; and (5) wish to be cared for at home. Defines respiratory care services as services provided on a part-time basis in the home of the individual by a respiratory therapist or other person skilled in respiratory therapy (as determined by the State), payment for which is not otherwise included within other items and services covered for such persons under the State's Medicaid plan. States would not be required to offer respiratory services of the same amount, duration, and scope to any persons except those who meet the above requirements. ***Effective date.***—Applies to services furnished on or after October 1, 1986. ***Outlay effect*** (in millions): Fiscal years: 1987 ..... −2 1988 ..... 0 1989 ..... 0 3-year total ..... −2

IV. MEDICAID PROVISIONS—Continued

Item	Present Law
22. New Jersey Respite Care Pilot Program (Section 645 of Senate amendment)	Medicaid does not currently cover respite care services except where provided under a home and community-based services waiver.

House Bill	Senate Amendment
No provision.	Requires the Secretary to enter into an agreement with the State of New Jersey to conduct a pilot project which would provide respite care services to Medicaid eligible elderly and disabled persons and other elderly and disabled persons for whom respite services are not otherwise reasonably and actually available or provided and who would be reasonably anticipated to require institutional care without the availability of these services. Defines respite care services as short-term and intermittent companion or sitter services, homemaker and personal care services, adult day care, inpatient care, and emergency respite as well as peer support and training for family caregivers. Requires that respite services be available to persons without regard to income (with cost-sharing on a sliding-scale basis related to income), but priority be given to persons who would be eligible for Medicaid benefits upon institutionalization. Requires the Secretary to pay New Jersey, in addition to payments the State is otherwise entitled to, an amount equal to 50 percent of the reasonable costs incurred for the project. The Federal payment for the project could not exceed $1 million for FY87, and $2 million for each of the fiscal years 1988 through 1990. No payment could be made for any fiscal year after FY90. The project would have a maximum duration of 4 years, plus an additional period of up to 6 months for final evaluation and reporting. Requires the Secretary to submit annual reports and a final report. Also requires the Secretary to waive requirements, including formal solitation and approval requirements, as will further the expeditious and effective implementation of the project. ***Effective date.***—Enactment. ***Outlay effect*** (in millions): Fiscal years: 1987 ..... 1 1988 ..... 2 1989 ..... 2 3-year total 5

V. MATERNAL AND CHILD HEALTH PROVISIONS

Item	Present Law
1. Authorization of Additional Maternal and Child Health Services Block Grant Funds (Section 4641 of House bill)	*(a) Additional Funds.*—DEFRA contained a permanent authorization level of $478 million for the Maternal and Child Health (MCH) Services Block Grant. Under the Balanced Budget and Emergency Deficit Control Act of 1985 (P.L. 99–177), MCH Block Grant funds are fully sequesterable, subject to the uniform reduction percentages for nondefense programs. *(b) Set-Aside for Newborn Genetic Disorders.*—Of the amounts appropriated, the Secretary is authorized to use not less than 10 nor more than 15 percent for special projects of regional and national significance—including maternal and child health improvement projects, and research, training, hemophilia, and genetics grants.

House Bill	Senate Amendment
(a) Additional Funds.—Authorizes the MCH Block Grant to spend $553 million for FY 1987, $557 million for FY 1988, and $561 million for fiscal years thereafter.	No provision.
(b) Set-Aside for Newborn Genetic Disorders.—Requires the Secretary to retain $7 million in FY 1987, $7.5 million in FY 1988, and $8 million in FY 1989 for projects for the screening of newborns for sickle-cell anemia and other genetic disorders. This set-aside is in addition to the existing set-aside for special projects of regional and national significance. The set-aside will sunset after FY 1989 and the funds will become available for allocation to the States. *Effective date.*—October 1, 1986. *Outlay effect* (in millions): Fiscal years: 1987 ..... 42 1988 ..... 68 1989 ..... 78 3-year total 188	

V. MATERNAL AND CHILD HEALTH PROVISIONS—Continued

Item	Present Law
2. Maternal and Child Health and Adoption Clearinghouse (Section 4642 of House bill)	The Secretary may provide technical assistance to the States to assist them to develop foster care and adoption assistance programs. The Secretary is required to periodically (1) evaluate the foster care, adoption assistance, and child welfare services programs; and (2) collect and publish data pertaining to the incidence and characteristics of foster care and adoptions in the United States. Each State is required to submit statistical reports as the Secretary may require with respect to children for whom payments are made under the foster care and adoption assistance programs, including information on legal status, demographic characteristics, location, and length of any stay in foster care.

House Bill	Senate Amendment
Requires the Secretary to establish, either directly or by grant or contract, a National Adoption Information Clearinghouse. The Clearinghouse is required to (1) collect, compile, and maintain data and information obtained from studies, research, and reports by public and private agencies, institutions, or individuals concerning all aspects of infant adoption and adoption of children with special needs; (2) compile, maintain, and periodically revise directories of information concerning crisis pregnancy centers, shelters and residences for pregnant women, training programs on adoption, educational programs on adoption, licensed adoption agencies, State laws relating to adoption, intercounty adoption, statistics on adoption, and any other information relating to adoption (for pregnant women, infertile couples, adoptive parents, unmarried individuals who want to adopt children, individuals who have been adopted, birth parents who have placed a child for adoption, adoption agencies, social workers, counselors, or other individuals who work in the adoption field); and (3) disseminate the most current and complete information regarding adoption, including directories compiled, maintained, and revised pursuant to (2) above. *Effective date.*—Enactment. *Oulay effect.*—Negligible.	No provision.

VI. ACCESS TO HEALTH INSURANCE COVERAGE PROVISIONS

Item	Present Law
1. Incentives for the Establishment of State Health Insurance Pools (Section 10251 of House bill)	States are not required to establish health insurance pools for the purpose of offering health insurance to people that are otherwise unable to purchase health insurance. However, 10 States have enacted laws establishing comprehensive health insurance associations. These associations are independent nonprofit corporations governed by a board and administered by an insurance carrier selected by the board. The 10 States base employer participation in such pools on whether the employer maintains a health insurance plan, rather than requiring all employers to participate whether or not they maintain a health insurance plan. Accordingly, only health insurance carriers who provide health insurance plans governed by State law are required to participate in such pools. Because the Employment Retirement Income Security Act (ERISA) preempts State law, employer-based, self-funded health plans have been exempted from any State mandate to participate in such pools. The existing State pools are financed primarily by beneficiary premiums. To the extent that the premium revenues are insufficient, the losses of the pool are shared among the health insurance carriers underwriting health insurance in the State. However, ERISA preempts State laws relating to employee benefit plans, except for laws relating to the regulation of insurance. Self-funded employer-based plans have been found to be exempt from State laws under the ERISA preemption. Accordingly, the self-funded plans do not share in the losses of the existing pools.

House Bill	Senate Amendment
(a) General Rule.—Amends Chapter 41 of the Internal Revenue Code of 1954 to provide for a tax on the wages paid by large employers that are not members of qualified State health insurance pools and that employ individuals to perform services in a State that has established such a pool. The tax is equal to 5 percent of the wages paid by the employer during the taxable year for services performed in the State by its employees.	No provision.
(b) Large Employer Defined.—A large employer is defined as an employer who, on each of some 20 days (each day being in different calendar weeks), employed 20 or more individuals for some portion of the day. The term does not include the United States, any State or political subdivision, any possession of the United States, or any agency or instrumentality of any of the foregoing (including the Postal Service and Postal Rate Commission), except that the term shall include any nonappropriated fund instrumentality of the United States.	
(c) Exception for Certain Churches and Associated Organizations.—Exempts church organizations from participation in the State health insurance pools which fund procedures that are contrary to their religious tenets.	
(c) Qualified Health Insurance Pool Defined.—A qualified health insurance pool is defined as any organization which: (1) is a nonprofit organization established pursuant to and regulated by State law; (2) permits any large employer doing business in the State to be a participating member; and (3) makes available (without regard to health status) to all residents of the State not entitled to Medicare, levels of health insurance typical of large employer group coverage. Any such level of insurance must limit the annual out-of-pocket expenses to specified limits and may not establish lifetime benefit limits for any individual less than $500,000. The coverage may provide for a choice of deductibles but not to exceed $1,000 per covered individual. The plan may exclude coverage for preexisting conditions for a period not to exceed 6 months. The coverage must include the purchase and repair of durable medical equipment.	

VI. ACCESS TO HEALTH INSURANCE COVERAGE PROVISIONS—Continued

Item	Present Law

House Bill	Senate Amendment
A qualified pool may charge a premium rate expected to be self-supporting, but such premium rate may not exceed 150 percent of average premium rates for individual standard risks in the State for comparable coverage. State health insurance pools may deny coverage for some or all services or other costs relating to abortions. The organization shall assess losses of the pool equitably among all participating members. The term "State" includes the District of Columbia and the Commonwealth of Puerto Rico. ***(e) Establishment of Qualified State Health Insurance Pools.***—Congress intends that each State shall establish a qualified health insurance pool by not later than January 1, 1988, or, if later, the end of the first regular State legislative session that begins after the enactment of this Act. ***Effective date.***—Applies to taxable years beginning on or after January 1, 1988. ***Outlay effect.***—None.	

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Item	Present Law
2. COBRA Technical Amendments Relating to Continuation of Employer-Based Health Insurance Coverage (Section 10252 of House Bill)	COBRA amended the Internal Revenue Code to prohibit deductions for employer contributions to group health plans maintained by private employers that do not provide continuation coverage to certain specified employees and their spouses and dependents who would otherwise lose their group health insurance coverage as a result of specified qualifying events. Qualifying events include: death of the covered employee; termination or reduction of hours of the covered employee's employment; divorce or legal separation of the covered employee from the employee's spouse; the covered employee becoming entitled to Medicare; or a dependent child ceasing to be a dependent child under the plan. COBRA also made comparable amendments to the Employment Retirement Income Security Act and the Public Health Service Act. *(a) Modification of Coverage.*—All qualified beneficiaries who would otherwise lose coverage as a result of a qualifying event are entitled to elect continuation coverage. The continuation coverage must be identical to the coverage provided under the plan to similarly situated beneficiaries for whom a qualifying event has not occurred. *(b) Maximum Period of Continuation Coverage.*—The continuation coverage period must extend from the period beginning on the date of the qualifiying event and end not earlier than 18 months after loss of coverage due to termination or reduction in working hours and 36 months in the case of other qualifying events. *(c) Grace Period for Payment of Premiums.*—The plan may require payment of a premium. No coverage need be provided under the plan if the beneficiary fails to make timely premium payments.

House Bill	Senate Amendment
	No provision.
(a) Modification of Coverage.—Amends the Internal Revenue Code to provide that if coverage is modified under the plan for similarly situated beneficiaries, such coverage shall be modified for all qualified beneficiaries.	
(b) Maximum Period of Continuation Coverage.—Amends the Internal Revenue Code to provide that in the case of a qualified beneficiary with respect to whom more than one qualifying event has occurred, the maximum period of coverage may be extended, but in no event may the coverage exceed a 36 month period (other than the period applicable to bankruptcies as described in section 10253 of the House bill; see item XX).	
(c) Grace Period for Payment of Premiums.—Amends the Internal Revenue Code to provide that the grace period for making timely payments is the longer of 30 days, the period the plan allows employees, or the period the insurance company allows the plan or employer, whichever the case may be.	

Item	Present Law
	(d) Election by Beneficiaries.—Each qualified beneficiary may elect continuation coverage. If the qualifying beneficiary is the covered employee (in the case of separation from service or a reduction of hours) or the spouse of the covered employee, the election is deemed to include election on behalf of any other qualified beneficiary who would otherwise lose coverage. *(e) Notice Requirement.*—The employer of any employee covered under a group health plan must notify the plan administrator within 30 days of the qualifying event in the case of the death of the employee, separation from service or reduction of hours of the employee, or the commencement of entitlement to Medicare benefits. In the case of other qualifying events, the covered employee or qualified beneficiary is responsible for notifying the plan administrator that a qualifying event has occurred. However, no time limit is specified in such events.

House Bill	Senate Amendment
(d) Election by Beneficiaries.—Amends the Internal Revenue Code to clarify that each qualified beneficiary is entitled to make a separate election with respect to continuation coverage and among the types of such coverage available under the plan.	
(e) Notice Requirement.—Amends the Internal Revenue Code to provide that in the case of qualifying events for which the covered employee or qualified beneficiary is responsible for notifying the plan administrator, such notice must be made within 60 days of the qualifying event.	
Effective date.—Effective as if the amendments had been included in COBRA.	
Outlay effect.—None.	

Item	Present Law
3. Continuation Coverage for Retirees in Cases of Bankruptcies (Section 10253 of House bill)	COBRA amended the Internal Revenue Code to prohibit deductions for employer contributions to group health plans maintained by private employers that do not provide continuation coverage to certain specified employees and their spouses and dependents who would otherwise lose coverage as a result of specified qualifying events. COBRA also made comparable amendments to the Employment Retirement Income Security Act and the Public Health Service Act. ***(a) Loss of Coverage of Retiree Through Bankruptcy.***—The reduction of hours of the covered employee's employment; divorce or legal separation of the covered employee from the employee's spouse; the covered employee becoming entitled to Medicare; or a dependent child ceasing to be a dependent child under the plan. ***(b) Period of Continuation Coverage.***—The continuation coverage period must extend from the period beginning on the date of the qualifying event and ending not earlier than 18 months after loss of coverage due to termination or reduction in working hours and 36 months in the case of other qualifying events. Continuation coverage may be terminated on the date on which the qualified beneficiary becomes entitled to Medicare. ***(c) Definition of Qualified Beneficiary in Reorganization Cases.***—A qualified beneficiary is defined as the covered employee of a group health plan (in the case when the qualifying event is the termination or reduction in hours of the employee) and any other individual who, on the day before the qualifying event, was a beneficiary under the plan as the spouse or dependent child of the employee.

House Bill	Senate Amendment
	No provision.
(a) Loss of Coverage of Retiree Through Bankruptcy.—Amends the Internal Revenue Code to provide that the filing of a Title XI bankruptcy proceeding, commencing on or after July 1, 1986, is considered a qualifying event for continuation coverage with respect to the employer from whose employment the covered employee retired at any time, if such an event resulted in the substantial elimination of coverage for specified qualified beneficiaries within 1 year before or after the filing of the bankruptcy.	
(b) Period of Continuation Coverage.—Amends the Internal Revenue Code to provide that the filing of a Title XI bankruptcy proceeding on or after July 1, 1986, which results in retirees' substantially losing health insurance coverage is a qualifying event, in which case, the maximum period of continuation coverage is life for the retiree or the retiree's widow. After the death of the covered retiree, the maximum period of continuation coverage is 36 months for the surviving spouse and dependent children. In the case of a Title XI bankruptcy as a qualifying event, entitlement to Medicare benefits does not terminate the period of entitlement to continuation coverage.	
(c) Definition of Qualified Beneficiary in Reorganization Cases.—Amends the Internal Revenue Code to provide that in the case of a Title XI bankruptcy as a qualifying event, the term qualified beneficiary includes a covered employee who had retired on or before the date of substantial elimination of coverage, and any other individual who, on the day before such qualifying event, is a beneficiary under the plan as the spouse or dependent child of the employee or as the surviving spouse of the employee.	

VI. ACCESS TO HEALTH INSURANCE COVERAGE PROVISIONS—Continued

Item	Present Law

House Bill	Senate Amendment
Effective date.—In general, the amendments are effective as if they had been included in section 10001 of COBRA. Notwithstanding this effective date and section 10001 of COBRA, the amendments made by this section and section 10001 of COBRA shall apply in plan years ending during the 12 month period beginning July 1, 1986, but only with respect to a qualifying event of Title XI bankruptcy, and the qualifying event of death of the covered employee occurring after a Title XI bankruptcy. The section defining Title XI bankruptcy as the qualifying event applies to covered employees who retired before, on, or after the date of enactment. *Outlay effect.*—Negligible.	

Item	Present Law
1. Extend Medicare Coverage and Hospital Insurance Tax to State and Local Government Employees (Section 661 of the Senate amendment)	In the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), P.L. 99-272, Medicare coverage and the corresponding hospital insurance payroll tax were extended on a mandatory basis to State and local government employees hired after March 31, 1986. COBRA also authorized States to elect to extend Medicare coverage to State and local government employees hired prior to April 1, 1986, by voluntary agreement with HHS. Medicare coverage and the hospital insurance payroll tax are mandatory for Federal employees. For wages paid in 1986 to Medicare-covered employees, the hospital insurance tax rate is 1.45 percent on the employer and 1.45 percent on the employee of the first $42,000 of wages (Code secs. 3101, 3111, and 3121(a)).

House Bill	Senate Amendment
No provision.	The provision extends Medicare coverage on a mandatory basis to employees of State and local governments not otherwise covered for Medicare under present law. These employers and their employees will become liable for the hospital insurance portion of the FICA tax, and the employees will earn credit toward Medicare eligibility based on their covered earnings. (The optional Medicare coverage provision enacted in COBRA is terminated.) The collection of the hospital insurance tax with respect to State and local government employees to whom the provision applies is to be carried out in the same manner as provided in COBRA with respect to employees hired after March 31, 1986. *Effective date.*—Medicare coverage and the corresponding hospital insurance payroll tax are extended to State and local employees (not otherwise covered by present law) effective for services performed after April 30, 1987. *Revenue effect* (in millions): Fiscal years: 1987 ..... 789 1988 ..... 2,095 1989 ..... 2,088 3-year total 4,972

Item	Present Law
2. Deposits of Social Security Contributions by State and Local Government Employers (Section 10002 of the House bill and section 662 of the Senate amendment)	*(a)* Each State may enter into a voluntary agreement with the Secretary of Health and Human Services to provide social security coverage for employees of the State government and any of its political subdivisions. A State which enters into a coverage agreement is liable for collecting and depositing with the Federal government employer and employee social security contributions on their own behalf and for sub-State entities. Payments of social security contributions are first made by the local subdivisions to the State, which also is responsible for verifying and consolidating the payments. The State then deposits these payments and the empropriate amounts with respect to its own employees with the Federal government on a twice a-month deposit schedule. *(b)* Private employers are required to make payroll tax payments under a schedule that links the frequency of deposits to the amount to taxes withheld. Large employers may make deposits as frequently as eight times a month, while small employers may make them as infrequently as one every three months. These rules also apply to deposits of Federal income taxes withheld by State and local governments from their employees. *(c)* Late deposits by State governments are subject to an interest charge at the rate of six percent per year. Private-sector employers pay an interest rate that is based on the prime interest rate charged by major commerical banks. This rate is adjusted semi-annually.

President's Proposal	Possible Option
(a) The House bill removes from the States the intermediary role of collecting social security contributions from sub-State entities. States are relieved of liability for collecting and verifying the social security contributions owed by its political subdivisions.	*(a)* Same as House bill.
(b) The House bill places all State and local government employers uner the same frequency of deposit schedule currently required for private employers and also for deposits of Federal income taxes withheld by State and local governments.	*(b)* Same as House bill.
(c) Under the House bill, State and local governments are subject to the same interest charge and penalties for late deposits as apply to private employers.	*(c)* Same as House bill.
Effective date.—These provisions are effective for payments of contributions due with respect to wages paid after December 31, 1986.	***Effective date.***—Same as House bill.
Revenue effect (in millions):	***Revenue effect.***—Same as House bill.
Fiscal years:	
1987 388	
1988 290	
1989 1,158	
3-year total 1,836	

Item	Present Law
3. Telephone Excise Tax (Sections 10301-02 of the House bill)	*Tax rate.*—A three-percent excise tax is imposed on local and toll telephone service and teletypewriter service. Under present law, the tax is scheduled to expire with respect to telephone bills first rendered after December 31, 1987 (Code section 4251). *(b) Exemptions.*—Exemptions from the tax are provided for private communications systems, installation services, certain calls from coin-operated telephones, news services (except local service), international organizations, the American Red Cross, servicemen in combat zones, nonprofit hospitals and educational organizations, and State and local governments.

House Bill	Senate Amendment
(a) Extension of tax.—The House bill extends the three-percent tax for two years, through December 31, 1989. *Effective date.*—The extension applies January 1, 1988 through December 31, 1989.	*(a) Extension of tax.*—No provision.
(b) Study of exemptions.—The House bill also requires the Treasury Department to study the effects of the exemption from the telephone excise tax for private telecommunications systems and other specific exemptions. The Treasury report to the Congress, including revenue effects of present-law exemptions and descriptions of types of persons benefitting from such exemptions, is to be made before January 1, 1988. *Effective date.*—Date of enactment. *Revenue effect* (in millions): Fiscal years: 1987 ..... 0 1988 ..... 1,337 1989 ..... 2,290 3-year total 3,627	*(b) Study of exemptions.*—No provision.

Item	Present Law
4. Extension of Portion of the Federal Unemployment Tax (FUTA) Due to Expire After 1987 (Section 10104 of the House bill)	An employer is subject to FUTA tax of 6.2% on the first $7,000 in wages paid to its employees. However, since the employer receives a credit of 5.4%, in recognition of the State unemployment taxes that the employer must pay, the net FUTA tax is 0.8%. Under present law, a portion of the total 6.2% rate—0.2%—is temporary and is scheduled to expire on December 31, 1987 (Code sec. 3301(1)). If this portion expires, the net FUTA rate (taking into account the 5.4% credit) will be 0.6%. The funds generated by this portion of the tax are used to repay general revenue advances made to the Extended Unemployment Compensation Account. These advances have been used to pay for the Federal Supplemental Benefit program and for the Federal share of the permanent extended benefit program. The additional 0.2% tax automatically expires at the beginning of the first year following the year in which the advances are repaid. Current economic projections indicate that advances will be fully repaid in mid-1987. This means that the gross FUTA tax rate will be 6.0%, and the net FUTA tax rate will be 0.6%, for the year beginning January 1, 1988.

House Bill	Senate Amendment
The bill provides that the temporary FUTA tax of 0.2% will remain in effect for 1988 and 1989, notwithstanding the anticipated repayment in 1987 of general revenue advances to the Extended Unemployment Compensation Account. ***Effective date.***—The provision applies to remuneration paid after December 31, 1986. ***Outlay effect*** (in millions): Fiscal years: 1987 ..... 0 1988 ..... 912 1989 ..... 1,282 3-year total 2,194	No provision.

Item	Present Law
5. Accelerated Collection of Certain Excise Taxes (Section 10321 of the House bill and section 663 of the Senate amendment)	Excise taxes on alcohol and tobacco taxes are paid semimonthly, with payments being due the following number of days after each semimonthly period: Days (a) Domestically produced and bulk imported distilled spirits ..... 30 (b) Bottled imported distilled spirits ..... 15 (c) Beer and wine ..... 15 (d) Tobacco 25

House Bill	Senate Amendment
Under the House bill, the excise taxes on tobacco, wine, and beer are due 14 days after the semimonthly period when the taxable event occurs.	Under the Senate amendment, the excise taxes on tobacco and distilled spirits are due 14 days after the semimonthly period when the taxable event occurs. Bottled imported distilled spirits are taxed on removal from customs custody.
Effective date.—In general, removals during semimonthly periods ending on or after December 31, 1986.	***Effective date***.—In general, taxes paid after September 30, 1986, for semimonthly periods ending on or after that date.
Revenue effect (in millions):	***Revenue effect*** (in millions):
Fiscal years: 1987 ..... 153 1988 ..... 1 1989 ..... 1 3-year total 155	Fiscal years: 1987 ..... 298 1988 ..... 1 1989 ..... 1 3-year total 300

Item	Present Law
6. Increases in Certain Tax Penalties (Sections 10311-12 of the House bill and section 664 of the Senate amendment)	
a. Penalty for failure to deposit taxes	Many taxpayers must deposit various taxes at dates prior to the close of their taxable year. Taxpayers who fail to comply with these requirements may be subject to a penalty of five percent of the underdeposit.
b. Penalties for substantial understatement of tax liability and for negligence	*(a) Substantial understatement.*—If a taxpayer substantially understates income tax for any taxable year, the taxpayer must pay a penalty equal to 10 percent of the underpayment of tax attributable to the understatement. An understatement is substantial if it exceeds the greater of 10 percent of the tax return or $5,000 ($10,000 for most corporations). *(b) Negligence.*—If any portion of an underpayment of tax is due to negligence, a penalty of five percent of the entire underpayment is imposed.

House Bill	Senate Amendment
The House bill increases this penalty from 5 to 10 percent. ***Effective date.***—Deposits required to be made after the date of enactment. ***Revenue effect*** (in millions): Fiscal years: 1987 ..... 750 1988 ..... 750 1989 ..... 750 3-year total 2,250	Same as House bill. *Effective date.*—Penalties assessed after the date of enactment. ***Revenue effect.***—Same as House bill.
(a) Substantial understatement.—The House bill increases the penalty for substantial understatement from 10 to 25 precent. ***Effective date.***—Returns due after December 31, 1986. ***(b) Negligence.***—No provision. ***Revenue effect*** (in millions): Fiscal years: 1987 ..... 96 1988 ..... 219 1989 ..... 270 3-year total 585	***(a), (b) Substantial understatement, negligence.***—The Senate amendment provides that if either the negligence or substantial understatement penalites (or both) apply, then the aggregate of these penalties must be at least 25 percent of the underpayment of tax. ***Effective date.***—Penalties assessed after the date of enactment. ***Revenue effect*** (in millions): Fiscal years: 1987 ..... 237 1988 ..... 267 1989 ..... 278 3-year total 782

Item	Present Law
7. Tax Treatment of Conrail Public Sale (Section 10331 of the House bill)	In general, the purchase of the stock in a corporation has no effect on the corporation's tax attributes (e.g., net operating loss carryovers, earnings and profits, and asset basis).

House Bill	Senate Amendment
Under the House bill, the sale of Conrail's stock will be treated as an asset sale. Conrail will be treated as a new corporation that purchased the assets after the public sale. Thus, the aggregate basis for Conrail's assets will be adjusted to reflect the stock purchase price (plus liabilities and other relevant items). Similarly, no NOL or other carryovers from periods before the public sale will be available for use in post-sale periods. In addition, no amount will be included in the gross income of Conrail by reason of the cancellation of any obligation or preferred stock of Conrail. Also, the House bill provides any post-closing payments for back wages must be capitalized. Finally, certain ESOP provisions are waived.	No provision.

Item	Present Law
8. Denial of Tax Benefits with Respect to Activities in Certain Foreign Countries (Section 1105 of the Senate amendment)	*(a) Foreign tax credit.*—A credit against U.S. income tax is available for foreign income, war profits, and excess profits taxes paid to a foreign country or a U.S. possession. The amount of the foreign tax credit may be reduced, however, in certain circumstances. For example, a taxpayer that participates in or cooperates with an international boycott will be denied a foreign tax credit for taxes paid on income derived within the countries associated with the boycott. *(b) Deferral.*—U.S. owners of foreign corporations generally may defer U.S. tax on the corporations' income until the income is repatriated. However, this deferral of U.S. tax does not apply to certain kinds of income earned by U.S.-controlled foreign corporations, including income derived within countries associated with an international boycott in which the taxpayer participates or with which the taxpayer cooperates.

House Bill	Senate Amendment
(a) Foreign tax credit.—No provision.	*(a) Foreign tax credit.*—Denies foreign tax credit for taxes paid on income attributable to activities conducted in foreign countries which repeatedly provide support for acts of international terrorism, have no diplomatic relations with the United States, or, in general, have governments not recognized by the United States.
(b) Deferral.—No provision.	*(b) Deferral.*—Currently taxes U.S. shareholders of controlled foreign corporations on the corporations' income attributable to activities conducted in foreign countries which repeatedly provide support for acts of international terrorism, have no diplomatic relations with the United States, or, in general, have governments not recognized by the United States. *Effective date.*—January 1, 1987. *Revenue effect* (in millions): Fiscal years: 1987 ..... 14 1988 ..... 26 1989 ..... 28 3-year total 68

Item	Present Law
9. Benefit Accrual Beyond Normal Retirement Age (Sections 1210–1211 of the Senate amendment)	Under present law, a defined benefit pension plan is not required to provide for benefit accruals for employees who continuing working past their normal retirement age (normally age 65). In addition, present law provides that a plan may exclude from participation employees who commence employment within five years of the normal retirement age under the plan.

House Bill	Senate Amendment
No provision.	The Senate amendment modifies the Age Discrimination in Employment Act (ADEA), the Employee Retirement Income Security Act of 1974 (ERISA), and the Internal Revenue Code to provide that an employee benefit plan may not require or permit the suspension of benefit accruals, or a reduction in benefit accruals, on account of the attainment of a specified age. In the case of a defined contribution plan, employer contributions may not be suspended or reduced on account of the attainment of a specified age. This restriction does not apply if the plan provides that an employee's benefit is increased to the actuarial equivalent of a benefit commencing at normal retirement age. A plan does not fail to meet the restriction merely because the plan excludes from participation employees who may be excluded because they commence employment within five years of normal retirement age. A plan amendment that eliminates a plan provision (in effect as of the date of enactment) allowing a lump-sum distribution upon attainment of normal retirement age without regard to separation from service is not treated as an impermissible reduction in accrued benefits. The Secretary of Labor or the Secretary of the Treasury is required to publish final regulations with respect to these provisions by February 1, 1988. *Effective date.*—The provision generally is effective as to individuals employed after December 31, 1988, with respect to accrual computation periods beginning after December 31, 1986. A special effective date applies to collectively bargained plans. *Revenue effect.*—The provision is estimated to reduce fiscal year budget receipts by less than $10 million annually.

Item	Present Law
10. Port Use Tax and Related Trust Fund; Inland Waterways Fuels Tax and Related Trust Fund (Sections 10341–10343 of the House bill)	
a. Port use tax	Federal expenditures for development, operation, and maintenance of U.S. channels and harbors ("ports") have been financed from general revenues. Present law does not impose Federal user taxes on the beneficiaries of these expenditures.

House Bill	Senate Amendment
Imposition of tax.—The House bill imposes an excise tax on the use of a U.S. port by a commercial vessel for loading or unloading of commercial cargo. The amount of the tax is 0.04 percent (four cents per $100) on the value of the cargo. The tax does not apply at a port on which no Federal funds have been used for construction, operation, or maintenance. *Payment of tax.*—The tax is payable by the importer, exporter, or shipper of the cargo. The tax is imposed only once with respect to transportation of any cargo on the same vessel. *Applicability of tax.*—The port use tax does not apply with respect to— (1) cargo the transportation of which is subject to the inland waterways fuels tax; (2) cargo when loaded or unloaded at ports in Hawaii or in a U.S. possession, or when loaded on a vessel at a U.S. port for ultimate use or consumption in Hawaii or a possession (the tax applies when cargo loaded in Hawaii or a possession is unloaded at a U.S. port); (3) transportation of passengers; (4) cargo consisting of fish or other aquatic animal life caught on the voyage; (5) cargo shipped by the U.S. Government or Federal agencies; and (6) de minimis transactions, to the extent prescribed in Treasury regulations. *Seaway tolls.*—The House bill provides for rebates of Saint Lawrence Seaway tolls (U.S. portion), to be made out of the Port Trust Fund, attributable to cargo subject to the port use tax. *Administration of tax.*—The port use tax is to be administered and enforced by the U.S. Customs Service in a manner similar to customs duties. *Effective date.*—January 1, 1987.	No provision.[1] [1] On March 16, 1986, the Senate passed H.R. 6, with amendments (the Water Resources Development Act of 1986). The revenue provisions of the Senate-passed bill include imposition of certain port user charges and establishment of a Harbor Maintenance Trust Fund; an increase in the inland waterways fuels tax and modifications to the Inland Waterways Trust Fund; and certain related provisions.

VII. REVENUE PROVISIONS—Continued

Item	Present Law
b. Port Trust Fund	No provision.
c. Inland waterways fuels tax	An excise tax of 10 cents per gallon is imposed on diesel and other liquid fuels used by commercial cargo vessels on 26 designated inland or intracoastal waterways (Code sec. 4042).
d. Inland Waterways Trust Fund	Amounts equivalent to revenues from the inland waterways fuels tax are transfered to the Inland Waterways Trust Fund in the Treasury. Amounts in the Trust Fund are available, as provided by authorization and appropriations Acts, for construction and rehabilitation expenditures for navigation on the waterways covered by the fuel tax.

House Bill	Senate Amendment
Establishment.—The bill establishes the "Port Infrastructure Development and Improvement Trust Fund" in the Treasury. The statutory provisions for the Trust Fund are placed in the Trust Fund Code of the Internal Revenue Code. *Funding.*—The Trust Fund receives amounts equivalent to revenues from the new port use tax. Also, the bill authorizes annual appropriations to the Trust Fund equal to $1 billion less the amounts received from the port use tax revenues for the fiscal year. *Expenditures.*—Amounts in the Trust Fund are to be available, as provided by appropriation Acts, for making expenditures for construction, operation, and maintenance of ports; rebates of Saint Lawrence Seaway tolls; and payments of Treasury expenses of administering the port use tax. *Effective date.*—January 1, 1987.	No provision.
The House bill adds the Tennessee-Tombigbee Waterway to the list of designated waterways with respect to which the inland waterways fuels tax applies.	No provision.
Expenditure purposes.—The House bill retains the present-law expenditure purposes for the Trust Fund, subject to the limitation that amounts from the Trust Fund cannot be used to finance more than one-third of the cost of seven specified inland waterways lock and dam projects, or more than one-sixth of certain specified relocation costs. *Statutory provisions.*—The House bill places the Trust Fund statutory provisions in the Trust Fund Code of the Internal Revenue Code. *Effective date.*—January 1, 1987.	No provision.

Item	Present Law

House Bill	Senate Amendment
Revenue effect (items a through d) (in millions):	
Fiscal year:	
1987 102	
1988 154	
1989 167	
3-year total 423	
(The revenue effect is the net increase in budget receipts, after income tax offsets, from the port use tax and the modfication to the inland waterways fuels tax.)	

Item	Present Law
11. Oil Spill Liability Trust Fund and Tax	
a. In general	Funds relating to oil spill damages and cleanups have been created under various Federal statutes, including: (1) Section 311(k) of the Federal Water Pollution Control Act (Clean Water Act) ($35 million revolving fund for oil spill cleanups, supported by fines, penalties, and general revenue appropriations); (2) The Trans-Alaska Pipeline Authorization Act ($100 million fund, financed primarily by a 5-cents-per-barrel fee on oil passing through the pipeline); (3) The Deepwater Port Act of 1974 ("Deepwater Port Liability Fund") ($100 million fund, financed by a 2-cents-per-barrel fee on oil loaded at a deepwater port); and (4) The Outer Continental Shelf Act Amendments of 1978 ("Offshore Oil Pollution Compensation Fund") $200 million fund with respect to offshore oil spills, financed by a maximum 3-cents-per-barrel fee on owners offshore oil).
b. Uses of fund	No provision.

House Bill	Senate Amendment
An Oil Spill Liability Trust Fund would be established in the Treasury to be funded in part by a 1.3-cents-per-barrel tax on domestic crude oil and imported petroleum products. Amounts in the Oil Spill Fund would be available for removal costs, certain damages sustained by U.S. claimants, and certain related costs associated with oil spills. Claimants generally would have the option of proceeding against the responsible party or recovering against the Fund, which could then proceed against the responsible party. The legislation would constitute an exclusive remedy for claims covered by the Fund. Liability of responsible parties would be on a strict, joint and several basis, with liability limits consistent with international agreements. Excess amounts remaining in the fund created by section 311(k) of the Federal Water Pollution Control Act would be transferred to the general fund of the Treasury.	No provision.
Amounts in the Oil Spill Fund would be available only for the following purposes (payments to any government would be limited to removal costs and administrative expenses related to removal costs): (1) Payment of costs incurred in cleaning up or preventing oil pollution from vessels of offshore facilities ("removal costs"), under the Federal Water Pollution Control Act, the Deepwater Port Act, and the Intervention on the High Seas Act. (2) Claims for injury to, or destruction of, real or personal property. (3) Claims for loss of subsistence use of natural resources. (4) Payment of otherwise uncompensated economic loss sustained by any U.S. claimant as a result of oil spills from vessels or offshore facilities. Compensable damages would include lost earnings and profits if: (a) loss is 25 percent or more of the claimant's earnings, or (b) in the case of seasonal activities, 25 percent of seasonal earnings are derived from affected activities.	No provision.

Item	Present Law
b. Uses of fund (Contd.)	
c. Tax on domestic and imported oil	An excise tax of 0.79 cent per barrel was imposed on— (1) crude oil received at a U.S. refinery; and (2) petroleum products (including crude oil, natural and refined gasoline, refined and residual oil, and certain other liquid hydrocarbon products) imported into the U.S. for consumption, use, or warehousing. Revenues equivalent to the tax were deposited in the Hazardous Substance Response Trust Fund ("Superfund"). The tax expired on September 30, 1985.

House Bill	Senate Amendment
(5) Payment of contributions to the International Fund for Compensation for Oil Pollution Damage if the conventions establishing this fund came into force with respect to the United States. Under regulations, contributions to the International Fund would be allowed only in proportion to the portion of such Fund used for purposes that are consistent with the uses of the domestic Oil Spill Liability Trust Fund. (6) Administrative costs, but only to the extent necessary for and incidental to the Implementation of the Comprehensive Oil Pollution Liability and Compensation Act. The liability of the Oil Spill Fund could not exceed $200 million for any single incident. Also, no payment could be made (except for removal costs) to the extent the payment would reduce the fund balance below $30 million. Claims against the Fund could be paid out of the Oil Spill Fund only. If the fund is insufficient to pay all claims, claims are to be paid in full in the order in which finally determined.	
Imposition of tax.—An excise tax of 1.3 cents per barrel would be imposed on domestic crude oil and imported petroleum products, using the same tax base as the Superfund petroleum tax.	No provision.
Credit for previous contributions.—A credit against the oil spill tax would be allowed (to the extent of prior contributions) for persons who contributed to: (1) the Deepwater Port Liability fund, or (2) the Offshore Oil Pollution Compensation Fund. (The balance in these funds would be transferred to the Oil Spill Fund.) This credit would be nontransferable.	
Termination date.—Tax liability would terminate after December 31, 1991.	
Effective date.—The tax is effective on January 1, 1987.	

Item	Present Law
d. Other transfers to Trust Fund	No provision.
e. Administrative provisions	No provision.

House Bill	Senate Amendment
In addition to the petroleum excise tax, the following amounts would be deposited in the Oil Spill Fund: (1) Amounts recovered, collected, or received from responsible parties under the Comprehensive Oil Pollution Liability and Compensation Act. Penalties with respect to payment of taxes would not be deposited in the Oil Spill Fund. (2) Amounts remaining in the Deepwater Port Liability Fund and the Offshore Oil Pollution Compensation Fund, as of the date of enactment. (3) Income on Oil Spill Fund investments. (4) The proceeds of authorized borrowing by the Oil Spill Fund, not to exceed $300 million in outstanding indebtedness at any time. (5) Penalties and recoveries under the Federal Water Pollution Control Act.	No provision.
The Oil Spill Liability Trust Fund would be established as a trust fund in the Internal Revenue Code. The Oil Spill Fund would be authorized to borrow, as repayable advances, up to $300 million at any one time to carry out the purposes of the Fund.	No provision.
Effective date.—The oil spill tax and trust fund provisions would be effective on January 1, 1987.	
Revenue effect (items a–e) (in millions): Fiscal years: 1987 ..... 1988 ..... 23 1989 ..... 47 3-year total 50 120	

Item	Present Law
12. Appropriations for IRS Enforcement (Section 665 of the Senate amendment)	The Internal Revenue Service (IRS) is responsible for administering almost all of the tax laws. The cost of the entire IRS is funded through annual appropriations of general revenues.

House Bill	Senate Amendment
(The House bill includes a provision relating to IRS appropriations for fiscal year 1987.)	The Senate amendment provides for changes in the funding levels appropriated to specific IRS functions for fiscal year 1987. Increased funds would be directed to functions involving examination, collection, and related tax compliance activities, as follows:

Salaries and expenses	$95,147,000
Processing tax returns	1,332,902,000
Examinations and appeals	1,623,162,000
Investigation, collection, and taxpayer service	1,196,581,000

These changes in funding would be effective only if the allocation to the Senate Appropriations Committee for the budget for fiscal year 1987 for the IRS is increased by $300,000,000 in both new budget authority and outlays.

VIII. OTHER PROVISIONS

Item	Present Law
1. Accelerate General Revenue Sharing Payment	The general revenue sharing program provides unrestricted grants totalling $4.4 billion in FY 1986 to all local governments—counties, municipalities, townships and Indian tribes. Payments are made quarterly. Payments for the third quarter of FY 1986 would be made on or before October 5, 1986. FY 1987 begins on October 1, 1986.
2. Customs User Fees (Section 10361 of House bill)	The Consolidated Omnibus Budget Act of 1985 (P.L. 99-272) for the first time imposed a schedule of customs users fees to cover Customs' costs of processing the arrival of vessels, trucks, trains, private boats and planes, and passengers. No fees were imposed, however, on the processing of commercial merchandise. The total revenues from such fees are approximately $200 million per year.

House Bill	Senate Amendment
No provision.	The general revenue sharing payments scheduled to be made on or before October 5, 1986 would be required to be made no later than September 30, 1986. *Effective date.*—Enactment. *Outlay effect* (in millions): Fiscal years: 1987 ..... −680 1988 ..... 0 1989 ..... 0 3-year total ..... −680
Imposes a customs user fee on all formal entries of imported merchandise for consumption based on the customs value of such merchandise of 0.5% ad valorem for the period 12/1/86 through 9/30/87 and 0.2% ad valorem thereafter. The provision would not apply to informal entries or to articles classifiable under items in schedule 8 of the Tariff Schedules. These fees would be in addition to the processing fees required under present law. The proceeds of such fees would be deposited in a separate account within the general fund of the Treasury and be available, subject to appropriation, to the Customs Service for carrying out its operations. On 9/30/88 and every two years thereafter, the Secretary of the Treasury would be required to submit a report to the Congress concerning any necessary fee adjustments to bring the account into a zero balance and to ensure that the fee reflects the actual costs of the services provided. *Effective date.*—December 1, 1986. *Outlay effect* (in millions): Fiscal years: 1987 ..... −1,830 1988 ..... −940 1989 ..... −1,000 3-year total ..... −3,770	